DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245549

June 24, 2014

Mr. Tim Swoboda, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

Dear Mr. Swoboda:

SUBJECT: DISPOSITION OF REMEDIES
Cycle Start Date: April 22, 2014

PRIOR NOTICE

On May 7, 2014, we informed you that we may be imposing a remedy due to the failure of your facility to be in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs.

SUBSEQUENT VISITS AND SUMMARY OF ENFORCEMENT REMEDIES

The Minnesota Department of Health conducted a revisit of your facility on June 12, 2014. The revisit found your facility to be in substantial compliance with the participation requirements effective May 13, 2014. As a result of the survey findings, the final status of remedies is as follows:

- Mandatory denial of payment for new Medicare and Medicaid admissions, which was to be effective July 22, 2014, will not be imposed
- Mandatory termination, which was to be effective October 22, 2014, will not be imposed

Therefore, no remedies against your facility have gone into effect for this enforcement cycle.

CONTACT INFORMATION

If you have any questions regarding this matter, please contact Jan Suzuki, Program Representative, at (312) 886-5209.

Sincerely,

Jan Suzuki
Principal Program Representative
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans

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
245549	A. Building B. Wing **01 - MAIN BUILDING 01**	6/12/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

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 K0025	**05/13/2014**	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/22/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245549

May 7, 2014
Certified Mail

Mr. Tim Swoboda, Administrator
Good Samaritan Society – Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

Dear Ms. Swoboda:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: April 22, 2014

FEDERAL MONITORING SURVEY

On April 22, 2014, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) at Good Samaritan Society - Mountain Lake to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. As the surveyor informed you during the exit conference, the FMS revealed that your facility was not in substantial compliance, with the most serious deficiency at Scope and Severity (S/S) level E, cited as follows:

- K25 -- S/S: E -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS are enclosed with this letter on form CMS-2567.

PLAN OF CORRECTION (POC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable Plan Of Correction (POC) for the enclosed deficiency cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice
- How the facility will identify other residents having the potential to be affected by the same deficient practice

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
- The date that each deficiency will be corrected
- An electronic acknowledgement signature and date by an official facility representative

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Stephen Pelinski, Branch Manager
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION
CMS has established an Informal Dispute Resolution (IDR) process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to, Stepehen Pelinksi, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care
- Remedies imposed
- Alleged failure of the surveyor to comply with a requirement of the survey process
- Alleged inconsistency of the surveyor in citing deficiencies among facilities
- Alleged inadequacy or inaccuracy of the IDR process

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

LIFE SAFETY CODE (LSC) WAIVERS
If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is July 22, 2014.

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings we are imposing the following remedy:

- Mandatory denial of payment for new admissions effective July 22, 2014

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Mandatory denial of payment for all new Medicare admissions is imposed effective July 22, 2014, if your facility does not achieve compliance within the required three months. This action is mandated by the Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). We are notifying National Government Services that the denial of payment for all new Medicare admissions is effective on July 22, 2014. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective July 22, 2014.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION
If your facility has not attained substantial compliance by October 22, 2014, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION
Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) and Nurse Aide Competency Evaluation Programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 22, 2014, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society – Mountain Lake will be prohibited from offering or conducting a NATCEP for two years from July 22, 2014. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS
This formal notice imposed the following remedy:

- Mandatory denial of for new admissions July 22, 2014

If you disagree with the finding of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. **A written request for a hearing must be filed no later than 60 days from the date of receipt of this notice.** Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

It is important that you send a copy of your request to our Chicago office to the attention of Tamika J. Brown.

A request for a hearing should identify the specific issues and the findings of fact and

conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

CONTACT INFORMATION
If you have any questions, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602.

Sincerely,

Gregg Brandush
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)
Resident Identifier Key

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health
National Government Services

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EVOZ
Facility ID: 00755

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245549**
2. STATE VENDOR OR MEDICAID NO. (L2) **477840500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE**
(L4) **745 BASINGER MEMORIAL DRIVE**
(L5) **MOUNTAIN LAKE, MN** (L6) **56159**

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 **04/21/2014** (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) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **55** (L18)
13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on April 21, 2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 05/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/19/2014 (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 **02/01/1991** (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 **04/22/2014** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245549

June 19, 2014

Mr. Tim Swoboda, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, Minnesota 56159

Dear Mr. Swoboda:

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 progra.

Effective March 27, 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 to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 1, 2014

Mr. Tim Swoboda, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, Minnesota 56159

RE: Project Number S5549024

Dear Mr. Swoboda:

On March 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 27, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 21, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 7, 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 February 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 20, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 27, 2014, effective March 20, 2014 and therefore remedies outlined in our letter to you dated March 17, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 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

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245549	A. Building B. Wing	4/21/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

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 ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
F0241	483.15(a)		03/20/2014
F0244	483.15(c)(6)		03/20/2014
F0253	483.15(h)(2)		03/20/2014
F0282	483.20(k)(3)(ii)		03/20/2014
F0312	483.25(a)(3)		03/20/2014
F0323	483.25(h)		03/20/2014
F0329	483.25(l)		03/20/2014
F0364	483.35(d)(1)-(2)		03/20/2014
F0371	483.35(i)		03/20/2014
F0428	483.60(c)		03/20/2014
F0465	483.70(h)		03/20/2014

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	KS/KFD	05/08/2014	03048	04/21/2014
Reviewed By CMS RO				

Followup to Survey Completed on: 2/27/2014

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
245549	A. Building B. Wing **02 - 2013 LINK ADDITION**	4/7/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

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 K0052	**03/03/2014**	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		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/KFD	05/08/2014	22373	04/07/2014
CMS RO				

Followup to Survey Completed on: 2/25/2014

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
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EVOZ
Facility ID: 00755

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245549**
2.STATE VENDOR OR MEDICAID NO.
(L2) **477840500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE**
(L4) **745 BASINGER MEMORIAL DRIVE**
(L5) **MOUNTAIN LAKE, MN** (L6) **56159**

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 **02/27/2014** (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)
09/30

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

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): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
CCN- 24-5549

At the time of the standad survey on February 27, 2014 the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 03/31/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/21/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1991
(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

Certified Mail # 7011 2000 0002 5143 7890

March 17, 2014

Mr. Tim Swoboda, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, Minnesota 56159

RE: Project Number S5549024

Dear Mr. Swoboda:

On February 27, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street, Marshall, MN 56258
Office: (507) 537-7158, Fax: (507) 537-7194

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 April 8, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 8, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually

occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 May 27, 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 August 27, 2014 (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 a PoC 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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205, Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING ______ B. WING ______	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purpose of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operation Manual.	
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 11 of 52 residents (R10, R13, R26, R31, R32, R36, R39, R45, R53, R65 & R75) who were observed during meal service. Findings include: A dignified dining experience was not provided for 11 residents (R10, R13, R26, R31, R32, R36, R39, R45, R53, R65 & R75) who when interviewed, expressed dissatisfaction with not being served their meals at the same time as their tablemate's.	F 241	approved Kmt 3/27/14 RECEIVED MAR 27 2014 Minnesota Department of Health Marshall	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 3/25/14

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
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F 241	Continued From page 1 During an interview on 2/25/14, at 11:40 a.m. R10 stated, "I don't like it, they don't serve the entire table, they say it is by how you come to the dining room but how do they know? It was hard to adjust to tablemate's finishing their food before I even got mine. At first I felt awkward but now I'm getting used to it." R10 verified that her dissatisfaction had been expressed to the staff on numerous occasions. According to review of the medical record, R10 had a Brief Interview for Mental Status (BIMS) score on 10/1/13, of 15/15 which indicated cognitively intact. During subsequent observation/interview on 2/26/14 at 5:44 p.m. R10 was observed seated in the dining room with 3 tablemate's. R10 expressed frustration stating that she had been seated at the table since 5:05 p.m. and still had not yet received her food. Two of the three other residents at R10's table had finished their evening meals while R10 and R31 waited for their food to arrive. During an interview on 2/25/14, at 5:39 p.m. R13 stated, "I'm not hungry, but the principal is, they get you down here to get the food and you wait with no food while the others at the table eat. The principal should be to all eat at the same time, I don't like this and I feel left out!" During an interview on 2/26/14, at 1:00 p.m. while seated alone eating the noon meal, R13 verified the meals were not enjoyable because of the long wait for meal service and delivery of food. When questioned about the meal, R13 was unable to identify the meat she had been eating and stated, "I don't know what this is, I really don't, it is so dry." R13 verified dissatisfaction with the meals served had been expressed to the staff numerous times. R13 had a BIMS score on 11/27/13, of	F 241	F241 DIGNITY AND RESPECT OF INDIVIDUALITY Resident #13 has been consulted and has established that she does not appreciate being called "Hon". Staff were informed during inservices held on 3/4/14, 3/6/14, 3/13/14; 3/17/14, 3/19/14 & 3/20/14 on the rights and dignity of all residents and that we need to address them in a fashion which they prefer and find respectful. Inquiries of residents about how they are addressed by staff is done at the time of admission and will continue to be recorded if they have a preferred name. The Social Worker or her designee will survey several residents each week times one month and then once a month times 3 months to determine if they feel they are addressed in an appropriate fashion. All findings will be presented at the regular monthly Quality Assurance meetings and any further action, if needed will be determined by the interdisciplinary team.	

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Marshall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING ______ B. WING ______	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 241	Continued From page 2 15/15 which indicated cognitively intact. During an interview on 2/25/14, at 11:15 a.m. R26 stated, "We should be served at the same time, it is uncomfortable to eat when everyone is not served at the same time. It's just good manners." R26 verified that dissatisfaction with the meal service had been expressed to the staff on numerous occasions. R26 had a BIMS score on 1/29/14, of 13/15 which indicated cognitively intact. During observation/interview on 2/26/14, at 5:44 p.m. R31 was observed seated in the dining room with 3 tablemates. R31 and R10 had not been served their meals; the 2 other tablemate's were observed finishing their meal. R31 confirmed that she had been waiting since approximately 5:10 p.m. (34 minutes) to be served and that R10 had waited even longer. R31 expressed frustration with the time waiting to be served and also with eating at different times than her tablemate's. R31 confirmed that this occurrence happened often. R31 had a BIMS score on 1/16/14, of 15/15 which indicated cognitively intact. During an interview on 2/25/14, at 11:20 a.m. R32 expressed dissatisfaction with the long wait for meal service while others who arrived after her were served first. R32 stated, "I'm ok, what can you do, but I don't like watching others get served before me when I was here before them and I don't like watching other people eat when I don't get served with them." Another lady at the table received her meal at 11:15 a.m. and R32 did not receive her meal until 11:40 a.m. (25 minutes later). During an interview on 2/25/14, at 5:39 p.m. after waiting 39 minutes for supper meal service, R32 stated, "This makes me angry	F 241	Concerns with the dining experience have been and continue to be evaluated. Current policy is to provide "Open Meals" which states we will serve residents in the order in which they enter the dining room and residents will not wait more than 10 – 15 minutes for their meal. Dietary staff were educated on 3/4/14 & 3/19/14, and Nursing staff were educated on 3/6/14, 3/13/14 & 3/20/14 on the need to provide timely service in the dining room in a manner acceptable to each resident and serve food that is palatable and enjoyed by residents. A Food Committee has been established with representation from Residents, Nursing, Dietary, Activities, and Social Service. This committee has met on 2 occasions, on 3/17/14 & 3/20/14 and will continue to meet at least monthly to explore all issues associated with the dining experience, including how meals are scheduled, menu choices and ways foods are served and presented. Each resident that is able to be interviewed will be polled to determine their preferences and allow them input into any changes that might be made.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 3 because I always have to wait so long. This delay is not good." R32 verified dissatisfaction with the meal service had been expressed to the staff on numerous occasions. R32 had a BIMS score on 10/1/13, of 9/15 which indicated moderate cognition impairment. During an interview on 2/25/14, at 5:50 p.m. while a family member (FM) was seated next to F36, the FM stated, "It is not uncommon to have to sit in this room and wait 45 minutes to be served. It is whoever comes first gets served first but it still takes 45 minutes of waiting. It depends on the servers and who the staff are for how long it takes to get service." R36 stated, "Having to wait and watch others eat makes me hungrier by the minute." F36 verified dissatisfaction had been expressed to the staff on numerous occasions. R36 had a BIMS score on 10/1/13, of 99 which indicated the resident was unable to complete the interview. During an interview on 2/25/14, at 11:35 a.m. R39 stated, "If you come in late you get served last. If you come first you get served first. I don't like it but I am used to it now." R39 was sitting at a table with 5 other ladies. R39 verified dissatisfaction with the meal service had been expressed to the staff on numerous occasions. R39 had a BIMS score on 10/1/13, of 14/15 which indicated cognitively intact. During observation/interview on 2/26/14 at 5:45 p.m. R45 was observed seated in the dining room with 3 tablemates. Two of the three residents seated at the table had received their meals at 5:30 p.m. and R45's tray arrived at 5:45 p.m. R53 remain seated at the table while the other three residents consumed their food. R45 indicated	F 241	Periodic audits to determine serving times of various meals will be done at least 2 X weekly by the dietary manager or her designee for the first month and then weekly x 3 months and then periodically as needed and as schedules are adjusted. Meal quality will be audited by the Dietary Manager or her designee for at least 3 meals per week for the first month and then at least one meal per week for the next 2 months. All audit results will be reported at the Food Committee Meeting and at the monthly QA meetings and further action, if necessary will be determined by the interdisciplinary committee. Completion Date 3/20/2014	3/20/14

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F 241	Continued From page 4	F 241		

that no ever receives their meals at the same time so they can eat together. R45 stated you arrive at 5:00 p.m. and sit and wait. R45 stated, 'Sometimes it is a half an hour, sometimes it is an hour!' R45 had a BIMS score on 12/4/13 of 15/15 which indicated cognitively intact.

During observation/interview on 2/26/14, at 5:45 p.m. R53 summoned the surveyor to the table. R53 indicated her frustration with the meal service as she had been in the dining room since 5:00 p.m. R53 stated "it is like this all the time; You come at 5 and you wait. It can be 30 minutes, 45 minutes or an hour! We never get our food at the same time." R53 stated that two tables received their meals at 5:30 p.m., R45 received his meal at 5:40 p.m. It was observed that R53 was served at 5:50 p.m. R53 had a BIMS score on 12/25/13 of 15/15 which indicated cognitively intact.

During an interview on 2/25/14, at 11:43 a.m. R65 stated, "It doesn't matter when you come here, you wait." R65 further verified she dislikes the long "wait" times for meal service and thinks that may be a reason for the overcooked vegetables and meats routinely. R65 verified dissatisfaction with the meal service had been expressed to the staff on numerous occasions. R 65 had a BIMS score on 10/1/13, of 15/15 which indicated cognitively intact.

During an interview on 2/25/14, at 11:23 a.m. R75 stated "It would be nice if we were all eating together". Another resident at the same table received the meal at 11:15 a.m. and 25 minutes later, R75 received her meal at 11:40 a.m. During an interview on 2/25/14, at 5:45 p.m. R75 verified she came to the dining room at 5:00 p.m.

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GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

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F 241	Continued From page 5 and it was not unusual to wait forty five minutes or longer to be served the evening meal. R75 verified dissatisfaction had been expressed to the staff on numerous occasions. R75 had a BIMS score on 10/1/13, of 15/15 which indicated cognitively intact. During several observations in the dining room during meal service, dietary aides referred to R13 "Hon". It was noted on 2/26/14, at 1:00 p.m. that R13 was asked whether she needed anything else while in the dining room and the dietary aide referred to her as "Hon" several times. R13 stated to the surveyor, "Do you hear that? Why do they bother to put my name right here on the table for everyone to see and then still call me pet names when my name is [R13]!" R13 confirmed this occurs frequently and does not want a single person identified as using the terms: Hon, Honey or Darling but prefers staff to address her by name. A review of the facility policy dated 8/12, titled, "Open Dining" read, Residents do not wait more than 10-15 minutes to be served. Batch cooking is required to ensure high-quality food with nutrient retention. Food should be kept no longer than 30 minutes on the steam table. During interview on 2/27/14, at 9:49 a.m. the dietary manager verified that residents are to be served as they come into the dining room. During interview on 2/27/14, at 1:11 p.m. the dietary manager (DM) confirmed the wait time during the supper meal on 2/26/14 for some of the residents was up to an hour. The DM indicated this was unusual stating, " We've watched tapes too and we've never found	F 241		

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F 241	Continued From page 6 anywhere that the wait time was over a half hour." The DM stated that during the evening meal a half hour wait time for meal service is acceptable because all residents tend to be present in the dining room at 5:00 p.m., "and everybody can't be first". The DM confirmed that only two dietary staff are routinely responsible for serving food to all of the residents and that no other staff are utilized to assist with food service during meal times.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to act upon resident grievances related to quality of food and timeliness of food service. This had the potential to affect all residents who received their meals from the facility's kitchen. Findings include: During interview on 2/26/14, at 2:30 p.m. R33 stated, "The food isn't very good here". R33 further stated the timeliness of food service, the quality of the food and the temperature of the food being too cold was an issue as well. R33 indicated that about a month ago the residents	F 244	F244 FAILURE TO LISTEN TO AOR ACT ON GROUP GRIEVANCE OR RECOMMENDATIONS Issues addressed at the monthly Resident Council Meeting and all other concerns voiced by residents and/or families will be logged and addressed by appropriate staff in a timely manner. Each concern will be recorded on the GSS#213 Suggestion or Concern form and will be directed to the appropriate department head to investigate and address. Completed forms will be reviewed and filed and will be kept in a confidential file by the Social Worker. The Social Worker or her designee will audit all forms for completeness and evidence of follow-up. The Social Worker will report trends and actions at the monthly Quality Assurance meeting and any further action, if needed will be determined by the interdisciplinary team. Completion Date 3/20/2014	3/20/14

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F 244	Continued From page 7 were served meatballs that tasted like they had been "taken off of some leftover spaghetti; there were people who usually don't complain about the food that were complaining about that". She further stated, "They just plop it on the plate". R33 confirmed the food did not look appetizing and stated although she doesn't care for meat, a sprig of green on the plate would improve the appearance. R33 stated these concerns had been brought up several times at resident council meetings with no improvement. During interview on 2/24/14, at 12:50 p.m. R53 expressed dissatisfaction with the food served stating, "Today at lunch the noodles were cold, the chicken breast was dry with no gravy and the green bean casserole was not good. They will give you your yogurt on a hot plate and your omelet on a cold plate! The food is usually not the right temperature. They keep saying they are working on it but it doesn't change". The resident council meeting minutes were reviewed and documentation included: (1) 9/11/13- brought up the concern of how the coffee cups are cleaned as they have been dirty when coffee is served to residents; people have left her table after waiting over an hour for their food; Other residents agreed and questioned the serving priority between the Village and the Lodge; [resident] also brought up that food has been inadequately prepared; ribs have been burnt and potatoes have been burnt and/or served raw. According to the notes, staff in attendance at the resident council meeting had indicated the issues would be communicated with the dietary manager (DM); (2) 8/14/13- several residents questioned the serving priority of who gets served when for	F 244		

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F 244	Continued From page 8 mealtimes; the dietary manager verified that mealtimes should be served on a "first come, first served" approach but residents said that is not how it happens. The dietary manager indicated she would talk with dietary staff at their next meeting and also reminded residents that the waiting time would not include time spent waiting before the official start of mealtimes and that she could check waiting times on videotape and talk to her staff; (3) 7/10/13-resident mentioned that the ice cream bar is usually melted by the time he receives it and the resident were reminded to ask dietary staff to place in freezer until the residents are ready for their frozen desserts; and (4) 6/12/13-several residents stated they have had to wait a long time for some meals to be served; and dietary manager will look into it. Documentation was lacking to indicate the concerns and recommendations expressed during the resident council meetings had been acted upon and discussed with residents to assure the grievances had been remedied. During interview on 2/27/14, at 12:58 p.m. with the licensed social worker (LSW) it was confirmed that residents concerns expressed at resident council meetings are not documented on a grievance form. The LSW stated that resident complaints related to dining are communicated to the dietary manager to address and follow-up. The LSW further stated, "The timeliness of the food service has been a long term issue and we're kind of at a loss". The LSW confirmed that staff do not routinely follow-up with concerns/complaints from the previous resident council meeting unless the residents bring the issues up again. She confirmed they had no	F 244		

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F 244	Continued From page 9 system to follow up with the concerns expressed from one meeting to the next. The LSW stated the resident council meeting notes are reviewed at the Quality Assurance (QA) quarterly meetings and that in the past the QA committee had implemented a resident food committee and that dining complaints had subsequently "dwindled", hence, the committee was eventually discontinued. The LSW further stated the food committee had met from 8/8/11 until 4/19/12, and it could be reinstated and "revamped" if necessary. During interview on 2/27/14, at 1:11 p.m. the dietary manager (DM) confirmed the wait time during the supper meal on 2/26/14 for some of the residents was up to an hour. The DM indicated this was unusual stating, " We've watched tapes too and we've never found anywhere that the wait time was over a half hour." The DM stated that during the evening meal a half hour wait time for meal service is acceptable because all residents tend to be present in the dining room at 5:00 p.m., "and everybody can't be first". The DM confirmed that only two dietary staff are routinely responsible for serving food to all of the residents and that no other staff are utilized to assist with food service during meal times. The DM also acknowledged that the tuna melts served for supper on 2/26/14, had been overcooked and the cook "should have started over". The facility form titled, Guidelines Meal Service/Dining Open Dining, revised 8/12 included: "Open dining includes the following: Residents do not wait more than 10 to 15 minutes to be served".	F 244		

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F 244	Continued From page 10 The facility procedure titled, Grievances, "Complaints or Concerns, revised January 2007 included: 2. When a resident, family member, visitor or staff member expresses a concern or grievance to a staff member related to resident care or services, it will be received in an open, friendly, non-judgmental manner and without discrimination or reprisal. 3. If the problem can be resolved immediately, the staff member will thank the individual for the information and proceed to take action regarding that problem. The grievance will then be documented on the Suggestion or Concern (GSS #213) and submitted to the center social services director. 4. If the complaint comes directly to the social services department, then the director of social services will complete a Suggestion or Concern (GSS #213) form upon receipt of the complaint. 5. The social services director will route the Suggestion or Concern (GSS #213) to the appropriate department head as soon as is reasonably possible... 6. An investigation must be completed for all grievances. The investigation may be informal, but must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint... 7. The social services director will then report the findings to the individuals filing the concern and to the center administrator... 8. If the grievance is not resolved, the center social services director will channel the concern directly to the administrator. On weekends and holidays, all concerns that pose an immediate danger will be handled by the weekend supervisor. The weekend supervisor will then take the necessary action to start an investigation	F 244		

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F 244	Continued From page 11 and notify the necessary personnel. It is recommended that non-threatening concerns will be forwarded to the social worker and resolved within two working days ; and 9. The social services director will maintain a confidential file of documented concerns and report trends and actions to the quality committee..."	F 244		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the environment was maintained in a comfortable manner by ensuring odors were addressed for 2 of 2 resident rooms (R13 & R48) that had a strong urine odor present throughout the survey. Findings include: Throughout each day of the survey 2/24, 2/25, 2/26 and 2/27/14, there was a strong urine odor observed to be present in R13 and R48's bedrooms and bathrooms. R13's record was reviewed. According to a Brief Interview for Mental Status (BIMS) assessment completed on 11/22/13, R13 had a score of 15/15 which indicated the resident's cognition was intact and the resident was interviewable. R13 was not aware of the urine odor smell in the room but did	F 253	F253 HOUSEKEEPING AND MAINTENANCE SERVICES Resident #13 had a personal chair which was brought in at the time of admission which was the source of the odor problem in the room. This chair is a family heirloom and was very special to this resident. The chair has been removed and the resident has been provided with another chair. Family is willing to have the chair cleaned or altered to eliminate any odors. The resident's bathroom has been cleaned and some personal items which were kept in the bathroom have been removed. Resident # 48 has an indwelling catheter but has spasms which cause the catheter to leak at times. The resident is encouraged to continue to drink adequate fluids to decrease the concentration of urine, the catheter bag is being changed several times each week, bedding is changed daily, and good peri care is being done.	

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F 253	Continued From page 12 verify she would not want visitors in the room with a strong urine odor. Although the administrator indicated the urine odor could have originated with the resident's personal chair located in the room, he was unaware if an attempt had been made to clean personal chairs and/or if the origin of the smell had been determined. It was noted the urine odor was also present in the bathroom. When interviewed on 2/26/14, at 1:00 p.m. nursing assistant (NA)-D stated, " They have tried to cover it up [the urine odor] with spray but it still smells. They have told us to just spray the room to cover the smell." NA-D showed the surveyor the product utilized to spray in the room. The label on the product indicated it was called, Tuscan garden odor counteractant. During interview with the director of nursing (DON) at 1:15 p.m. on 2/26/14, the DON verified administration was aware of the odor in R13's room and stated, "It has been a problem since she [R13] came here." During an environmental tour with the administrator and director of environmental services (DES) on 2/27/14 at 2:30 p.m., a strong urine odor was observed in R48's room. The odor was also noticed in the hallway. During the tour the administrator and DES verified the odor. The DES said the facility did not have a policy for urine odor control. R48's record was reviewed. According to the record, R48 had been assessed to have severe cognitive impairment as not able to be interviewed. During an interview with the DON on 2/27/14, at	F 253	Nursing staff were educated on 3/6/14, 3/13/14 and 3/20/14 on the need to identify odors, search for the source and eliminate the source as soon as possible. A walk through of the building was done to determine if there were any other areas with urine odor. A periodic walk through and audit for odors will be done weekly by the Environmental Service Manager or his designee for the next 2 months and then monthly for the next 3 months. Results of the audit will be presented at the monthly Quality Assurance Meeting and any further action, if necessary will be determined by the interdisciplinary team. Completion Date: 3/20/14	3/20/14

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F 253	Continued From page 13 2:00 p.m., the DON stated the urine odor present in R48's room could be due to the resident's use of an urinary catheter, but agreed that odor control should be addressed.	F 253		
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 provide oral hygiene as defined in the plan of care for 1 of 3 residents (R4) reviewed who were dependent upon staff for oral hygiene. Findings include: R4's medical record was reviewed. The care plan dated 2/26/14, indicated R4 had a problem of self care deficit related to weakness and limited mobility, and interventions included the need for total assist with oral care twice daily. In addition, review of the face sheet in the record indicated R4 had admission diagnoses which included multiple sclerosis and neuropathy. The quarterly Minimum Data Set (MDS) dated 11/27/13, identified that R4 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. The MDS also identified R4 as needing total assist from staff with grooming.	F 282		

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F 282	Continued From page 14 During observation on 2/25/14, at 11:06 a.m. it was noted that R4 had no upper teeth and the bottom teeth appeared dirty with debris. R4 stated during interview at that time that staff do not brush her teeth daily. R4 said the staff brush her teeth maybe once a week and further reported that staff had not brushed her teeth the previous evening or that morning during cares. During observation on 2/26/14, at 1:48 p.m. R4's lower teeth had what appeared to be a build-up of white material. R4 stated her teeth had not been brushed "last night or this morning." During interview with R4 on 2/27/14 at 9:00 a.m., R4 stated her teeth were not brushed the prior evening during cares. R4 stated NA-A was "a good one" and that she brushed her teeth when cares were provided. R4 again stated, "they might brush them once a week" (reference to other staff). During interview with NA-A on 2/27/14, at 9:30 a.m., NA-A stated she always brushes R4's teeth when cares are provided. However, NA-A stated she doesn't work with R4 that often. During interview with registered nurse (RN)-A on 2/27/14, at 8:53 a.m., RN-A verified the NAs were expected to provide oral cares during morning and evening cares. RN-A confirmed that R4 was cognitively intact and could accurately report whether or not staff had brushed her teeth as defined on the plan of care. During interview with the director of nursing (DON) on 2/27/14, at 10:05 a.m. she stated the expectation was that staff would follow the	F 282	F282 SERVICES BY QUALIFIED PERSONS PER CARE PLAN Resident #4 had been refusing oral care from some staff. The resident was interviewed and assessed to determine why she declined oral care from some staff and how we could modify the procedure so she would accept this and have satisfactory oral hygiene. Modifications were added to her care plan and nursing staff were educated on 3/6/14; 3/13/14, and 3/20/14 to how this resident would like to have her oral care performed and also on the need and importance of good oral hygiene for all residents. Staff were directed to notify the Case Managers of any refusals of care so residents could be assessed for the reason for refusal and modifications made to their care plans. All other residents were assessed for adequate oral hygiene. Residents will be monitored by the Director of Nursing or her designee for adequate oral hygiene 2-3 residents per week x one month and then 2-3 residents per month x 3 months. Results of these audits will be presented at the monthly Quality Assurance meetings and any further action, if necessary will be determined by the interdisciplinary team. Completion date: 3/20/2014	3/20/14

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F 282	Continued From page 15 resident's care plan and provide oral care both in the morning and the evening. The DON also verified that R4 was cognitively intact and would be accurate in reporting whether oral cares had been provided.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services to maintain oral hygiene for 1 of 3 residents (R4) reviewed who was dependent upon staff for oral hygiene. Findings include: R4's medical record was reviewed. The face sheet indicated R4 had admission diagnoses which included multiple sclerosis and neuropathy. The quarterly Minimum Data Set (MDS) dated 11/27/13, identified that R4 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. The MDS also identified R4 as needing total assist from staff with grooming. The care plan dated 2/26/14, indicated R4 had a problem of self care deficit related to weakness and limited mobility, and the interventions included the need for total assist	F 312		

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F 312	Continued From page 16 with oral care twice daily. During observation on 2/25/14, at 11:06 a.m. it was noted that R4 had no upper teeth and the bottom teeth appeared dirty with debris. R4 stated during interview at that time that staff do not brush her teeth daily. R4 said the staff brush her teeth maybe once a week and further reported that staff had not brushed her teeth the previous evening or that morning during cares. During observation on 2/26/14, at 1:48 p.m. R4's lower teeth had what appeared to be a build-up of white material. R4 stated her teeth had not been brushed "last night or this morning." During observation on 2/27/14 at 8:16 a.m., nursing assistant (NA)- A was observed providing morning cares for R4. NA-A was observed to brush R4's teeth. During additional interview with R4 on 2/27/14 at 9:00 a.m., R4 stated her teeth were not brushed the prior evening during cares. R4 stated NA-A was "a good one" and that she brushed her teeth when cares were provided. R4 again stated, "they might brush them once a week" (reference to other staff). During interview with NA-A on 2/27/14, at 9:30 a.m., NA-A stated she always brushes R4's teeth when cares are provided. However, NA-A stated she doesn't work with R4 that often. During interview with registered nurse (RN)-A on 2/27/14, at 8:53 a.m., RN-A verified the NAs were expected to provide oral cares during morning and evening cares. RN-A confirmed that R4 was cognitively intact and could accurately report	F 312	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Resident #4 had been refusing oral care from some staff. The resident was interviewed and assessed to determine why she declined oral care from some staff and how we could modify the procedure so she would accept this and have satisfactory oral hygiene. Modifications were added to her care plan and nursing staff were educated on 3/6/14; 3/13/14, and 3/20/14 to how this resident would like to have her oral care performed and also on the need and importance of good oral hygiene for all residents. Staff were directed to notify the Case Managers of any refusals of care so residents could be assessed for the reason for refusal and modifications made to their care plans. All other residents were assessed for adequate oral hygiene. Residents will be monitored by the Director of Nursing or her designee for adequate oral hygiene 2-3 residents per week x one month and then 2-3 residents per month x 3 months. Results of these audits will be presented at the monthly Quality Assurance meetings and any further action, if necessary will be determined by the interdisciplinary team. Completion date: 3/20/2014	3/20/14

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	245549	A. BUILDING ______ B. WING ______	02/27/2014

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F 312	Continued From page 17 whether or not staff had brushed her teeth as defined on the plan of care. During interview with the director of nursing (DON) on 2/27/14, at 10:05 a.m. she stated the expectation was that staff would follow the resident's care plan and provide oral care both in the morning and the evening. The DON also verified that R4 was cognitively intact and would be accurate in reporting whether oral cares had been provided.	F 312		
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 effectively analyze the risk associated with falling and to monitor the effectiveness of fall interventions for 2 of 4 residents (R13 & R23) who were reviewed for accidents and also failed to ensure that hot water temperatures in resident bathrooms (R3, R13, R22, R36, R42, R43, R48, R65 and R102) were maintained within a safe range and this had the potential to affect 9 of 16 resident bathrooms checked for hot water temperatures. Findings include:	F 323		

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F 323	Continued From page 18 R23 experienced a fall on 12/17/13, at 12:35 a.m., three hours and twenty minutes after receiving Ativan 0.5 mg (Clonazepam)on 12/16/13, at 9:15 p.m. R23 experienced a second fall on 12/31/13,at 1:10 a.m., three hours and fifty minutes after receiving Ativan 0.5 mg on 12/30/13 at 9:30 p.m. R23 experienced a third fall on 1/12/14, at 1:15 a.m. after receiving Ativan 0.5 mg two days prior on 1/9/14 at 7:30 p.m. R23 did receive Oxycodone 2.5 mg every 4 hours whenever necessary for pain according to the physician order and did receive the pain medication prior to the three falls. R23's active diagnosis from the Minimum Data Set (MDS)form dated 12/10/13, lists but is not limited to, hypertension, dementia, Parkinson's, anxiety and depression. The MDS further indicated a history of falls 2-6 months prior to admission. R23's Brief Interview for Mental Status (BIMS) dated 12/10/13, indicated a summary score of 15 out of a possible 15 for cognitively intact. R23's plan of care dated 12/19/13, read, "Comfort: Alteration in R/T (related to) DJD (degenerative joint disease) of lumbar spine; chronic low back pain w/ (with) hx (history) of being difficult to manage." One of the plans and approaches read, "Yelling at staff: often does this when having sig (significant) pain; notify nurse" The plan of care dated 12/17/13 read, "Mood/behavior; Alteration in R/T depression, anxiety, dementia, and pain, history of being combative, shouting at and berating staff prior to admission here, also calls out when experiencing pain." The plans and approaches went on to read,	F 323	F323 FREE OF ACCIDENT HAZARDS/SUPERVISION Residents #13 & 23 have been assessed and possible risk factors and root causes for falls have been evaluated. Medications have been adjusted and continued monitoring is in place. All subsequent falls have been assessed for root causes. All falls will be audited to assure all factors have been assessed by the Director of Nursing or her designee for the next 3 months. Results of these audits will be reported at the monthly Quality Assurance meetings and any further action, if necessary will be determined by interdisciplinary team. Water heaters were adjusted at the time of the survey and water temps on each wing have been checked at least weekly. Water temperatures are being monitored by the Environmental Services Director or his designee on all wings at least weekly to make sure temps are in the proper range. Audit results will be presented at the monthly Quality Assurance Committee meetings and any further action, if necessary will be determined by the interdisciplinary team. Completion date: 3/20/14	3/20/14

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F 323	Continued From page 19 " Explain purpose of your visit as well as cares and procedures, esp (especially) when anxious or experiencing pain. X/(example) behavior; calls out or hollers, inquire about res pain level and report to nurse." In the section for communication the plan of care read, "Deficit in cognitive changes R/T dementia; also has a history of confusion, agitation, anxiety with increased pain level causing difficulty with comprehension." R23's plan of care addressed the potential for adverse consequences R/T current medication regime and directed the staff to monitor for adverse consequences of all medications. When interviewed on 2/27/14, at 9:30 a.m. the director of nursing (DON) verified the three falls for R23 did not address any precipitating events to help prevent future falls which include the activity R23 had experienced prior to the fall. Information was not available related to the precipitating factors associated with the resident and including: toileting, positioning, pain medication use and observation of anxiety level prior to the three falls. The document titled, "Fallen or Injured Resident," directed staff to, "Complete the Incident Report, and the Falls Data Collection tool and to look for differences that may indicate a change in the risk for falls and to further explore risk factors and to assist in planning for resident safety." The forms were not completed, the plan of care was not updated and the facility failed to summarize all three falls were around 1:00 a.m. and an intervention should have been put into place following the use of Ativan for R23. During the environmental tour on 2/27/14, at 9:30 a.m. with the administrator and director of	F 323		

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F 323	Continued From page 20 environmental services, water temperatures were checked in a variety of resident bathrooms on each wing at the beginning of the wing and the end of the wing and on each side of the wing. Temperatures were record as Fahrenheit and noted in the following areas: (1) Resident 100 wing: R102-123 degrees, R43-122 degrees, R48-124 degrees; (2) Resident 200 wing: R3- 123 degrees, R13-124 degrees, R22- 122 degrees, R36- 122 degrees; and (3) Resident 300 wing: R42-125 degrees and R65-123 degrees. Interview with the administrator and director of maintenance on 2/27/13, at 9:30 a.m. verified the recommended federal temperatures can go up to 120 degrees for domestic water. The director of maintenance shared that the facility had a new hot water heater installed and stated, "A couple of weeks ago, maybe a month since the hot water heater was put in." The director of maintenance verified the water temperatures had not been checked since the new hot water heater had been installed. The facility policy titled, "Water Temperature/Hardness Record" dated November 2006 read, "These checks should be completed and recorded a minimum weekly or more often if needed or required. Recommended check areas would be laundry, kitchen and one resident room per wing." Interview with the director of nursing (DON) on 2/27/14, at 10:15 a.m. verified there were no resident burns associated with the hot water temps.	F 323		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 5 residents' (R46 and R23) drug regimens were free from unnecessary medications. The facility staff failed to attempt a gradual dose reduction (GDR) of an antidepressant medication, failed to provide rationale for continued usage, and failed to ensure adequate monitoring was conducted for the use of an antianxiety medication.	F 329	F329 DRUG REGIMINE IS FREE OF UNNECESSARY DRUGS Resident #46, who is on Prozac, was assessed and physician contacted. The physician has written his rationale for his desire to continue the use of the Prozac for this resident. Res #23 had not used the Ativan since January and this medication was discontinued by the physician. All other residents on similar drugs have had their medications reviewed and their physicians have been notified if necessary for dose reductions or for the physician to explain the rationale for continued use. All orders for medications will be monitored for their continued use and indication for use and their physicians will be notified if necessary. The Director of Nursing or her designee will audit the medications regimen of those residents taking psychoactive medications to determine if there is an appropriate dose reduction or a current physicians rationale for continued use on 4 residents weekly times one month and then 4 residents monthly for 3 months. All results of these audits will be reported at the monthly Quality Assurance meeting and any further action, if necessary will be determined by the interdisciplinary team. Completion date: 3/20/14	3/20/14

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F 329	Continued From page 22	F 329		

Findings include:

R46's record was reviewed and the face sheet indicated the resident had been admitted on 5/3/11 with diagnoses including depression. The physician orders indicated R46 had been restarted on Prozac 10 mg (milligrams) po (by mouth) daily on 2/25/13. Review of the quarterly Patient Health Questionnaire (PHQ-9)- a tool used to determine potential mood problems dated 12/11/13, indicated that R46 scored a zero (0) indicating no sign/symptoms related to depression.

Review of R46's care plan dated 12/18/13 identified R46 had an alteration in mood and behavior related to episodes of withdrawal, anxiety, and increased confusion as evidenced by complaints of not feeling well and tearfulness. Care plan approaches reviewed from 8/31/13 through 2/25/14, indicated R46 had no episodes of tearfulness or general physical complaints during this time frame.

Review of the Behavior-Medication monitoring form from the consulting pharmacist, dated 8/10/13, included: "Six month drug re-evaluation is due for: Prozac 10 mg daily. Please document dose response observed for controlling target depressive/dementia symptoms or attempt dose reduction if no longer needed". The form lacked documentation of response from either the nursing staff or the physician.

During interview on 2/27/14, at 1:45 p.m. the director of nursing (DON) confirmed the physician had not attempted a GDR or provided rationale as why R46 should continue on the medication

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F 329	Continued From page 23	F 329		

Prozac since starting the medication on 2/25/14. The DON confirmed the Behavior-Medication monitoring form dated 8/10/13 from the pharmacist had not been communicated to the physician for review of the pharmacy recommendation.
R23's record was reviewed. The medication administration record (MAR) indicated R23 had received Ativan 0.5 mg (antianxiety) on 12/16/13, at 9:15 p.m. and had experienced a fall on 12/17/13, at 12:35 a.m. (3 hours, 20 minutes later). In addition, the MAR indicated R23 had received Ativan 0.5 mg on 12/30/13 at 9:30 p.m., and had experienced another fall on 12/31/13, at 1:10 a.m. (3 hours & 50 minutes later).

R23's active diagnosis from the Minimum Data Set (MDS) form dated 12/10/13, included hypertension, dementia, Parkinson's, anxiety and depression. This MDS further indicated R23 had a history of falls having occurred 2-6 months prior to admission. A Brief Interview for Mental Status (BIMS) assessment dated 12/10/13, indicated R23 had scored 15/15 and was cognitively intact.

R23's current care plan dated 12/19/13 included; "Comfort: Alteration in R/T (related to) DJD (degenerative joint disease) of lumbar spine; chronic low back pain w/ (with) hx (history) of being difficult to manage." Approaches included; "Yelling at staff: often does this when having sig (significant) pain; notify nurse". In addition the care plan included; "Mood/behavior; Alteration in R/T depression, anxiety, dementia, and pain, history of being combative, shouting at and berating staff prior to admission here, also calls out when experiencing pain." Approaches included; " Explain purpose of your visit as well as cares and procedures, esp (especially) when

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F 329	Continued From page 24 anxious or experiencing pain. X/(example) behavior; calls out or hollers, inquire about res pain level and report to nurse." The communication section of the plan of care included: "Deficit in cognitive changes R/T dementia; also has a history of confusion, agitation, anxiety with increased pain level causing difficulty with comprehension." R23's plan of care addressed the potential for adverse consequences R/T current medication regime and directed the staff to monitor for adverse consequences of all medications. A review of the documentation on the form titled, Monthly Drug Review Documentation was conducted and the pharmacist had recorded "No Problems" on 12/12/13, 1/13/14 and 2/12/14, indicating no drug problems had been identified for R23. The form was signed by the consultant pharmacist. Physician orders indicated Ativan 0.5 milligrams (mg) was prescribed for anxiety or agitation whenever necessary (PRN) up to two times per day. According to WebMD, Ativan/Lorazepam is a drug used to treat anxiety. The WebMD site included, "Older adults may be more sensitive to the side effects of this drug, especially loss of coordination and drowsiness. Also, the elderly may not experience the relief of anxiety with lorazepam. It may have the opposite effect on the elderly, causing symptoms including mental/mood changes, sleeping problems, increase in sexual interest, or hallucinations. Loss of coordination drowsiness and sleeping problems may increase the risk of falling."	F 329		

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F 329	Continued From page 25 A review of the December 2013 MAR indicated R23 had received Ativan 0.5 mg for anxiety during the following times: (1) On 12/5/14, at 6:30 p.m. given for agitation and subsequent documentation revealed "calm/resting" at 7:00 p.m. (2) On 12/11/14, at 2:35 p.m. for general discomfort and the response to the medication was documented at 4:30 p.m. "Resting quietly." (3) On 12/16/13, at 9:15 p.m. with no indication/reason for administration nor effect upon R23 after administration of the medication; (4) On 12/18/13, at 3:00 p.m. with no indication/rationale nor results from receiving the medication; (5) On 12/20/13, at 9:30 p.m. with no indication or rationale for use with no results documented; (6) On 12/27/13, at 2:10 p.m. Ativan given for "c/o (complaints of) general pain/restless" with documentation lacking to indicate the response to the medication; and (7) On 12/30/13, at 9:30 p.m. Ativan administered for anxiety and no resident response to the medication documented. A review of the January 2014 MAR indicated Ativan 0.5 mg had been given on the following dates: (1) On 1/3/14, at 5:30 p.m. administered without an indication for use nor documented resident response; and (2) On 1/9/14, at 7:30 p.m. administered for anxiety without documentation describing the anxiety symptoms nor whether the resident responded to the medication. Documentation was lacking in the record for R23 related to consistent side effect monitoring for the use of the Ativan.	F 329		

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F 329	Continued From page 26 During interview with the consultant pharmacist on 2/27/14, at 8:40 a.m., the pharmacist verified R23's use of Ativan was not addressed in the pharmacy review for December 2013, January 2014 or February 2014. During interview with the director of nursing on 2/27/14, at 9:30 a.m., the DON verified there had been no recommendations from the pharmacist regarding R23's intermittent use of the medication Ativan without adequate indications for use and/or monitoring of the medication's effectiveness.	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide meals that are palatable and attractive for 7 of 52 residents (R10, R13, R33, R31, R45, R53 & R65) who were served meals. Findings include: During interview on 2/25/14, at 10:14 a.m. R10 expressed dissatisfaction with the food served at the facility stating, "It's edible; sometimes it's very good and sometimes it's very poor". During subsequent observation/interview on 2/27/14, at 11:45 a.m. R10 stated the tomato soup she was	F 364		

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F 364	Continued From page 27 served for supper on 2/26/14 was "not very good". R10 further stated she sent back the tuna melt sandwich that was served as it was burnt. Documentation on the Brief Interview for Mental Status (BIMS), dated 2/13/15 indicated R10 was cognitively intact and had a score of 15/15. When questioned about the meal on 2/25/14 at 5:39 p.m., R13 was unable to identify the meat she had been eating and stated, "I don't know what this is, I really don't, it is so dry." R13 had a BIMS score on 11/27/13, of 15/15 which indicated cognitively intact. During interview on 2/26/14, at 5:44 p.m. R31 stated the food served "isn't very good". While R31 awaited her meal, she pointed at her tablemate's (R51) sandwich and stated, "I hope mine's not like that". The bread on R51's tuna melt sandwich was noted to be a dark brown to black in color and appeared burnt. R31 indicated that one day when the planned meal was supposed to be meatloaf, meatballs were served instead, "and they were burnt". R31 further stated she had been served soup recently that had so much pepper seasoning added that "It burnt my throat going all the way down". During a subsequent interview on 2/27/14, at 11:45 a.m. R31 stated that when her meal was finally served the night before, she received tomato soup which she sent back to the dietary department, stating, "I can't eat tomato soup". R31 was offered minestrone soup which she declined and then staff found a can of vegetable soup and that was "ok". R31 had a BIMS score on 1/16/14 of 15/15 indicating she was cognitively intact.	F 364	F364 NUTRITIVE VALUE / APPEARANCE / PREFERED TEMPS The quality and the temperature of the food has been evaluated for improvement. Dietary staff were educated on 3/4/14 & 3/19/14 on the need to provide food that is properly cooked, remains moist and is served at the proper temperature. At least 2 menu choices continue to be offered at each meal for those with specific likes and preferences. A Food Committee has been established with representation from Residents, Nursing, Dietary, Activities, and Social Service. This committee has met on 2 occasions, on 3/17/14 & 3/20/14 and will continue to meet at least monthly to explore all issues associated with the dining experience including how meals are scheduled, menu choices and ways foods are served and presented. Each resident that is able to be interviewed will be polled to determine their preferences and allow them input into any changes that might be made by this Food Committee. The Dietary Manager or her designee will audit meals for quality and proper temperature on at least 3 meals per week for the first month and then 1 meal per week for the next 2 months. Completion Date: 3/20/14	3/20/14

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F 364	Continued From page 28 During interview on 2/26/14, at 2:30 p.m. R33 stated, "The food isn't very good here". R33 further stated the timeliness of food service, the quality of the food and the temperature of the food being too cold was an issue as well. R33 indicated that about a month ago the residents were served meatballs that tasted like they had been "taken off of some leftover spaghetti; there were people who usually don't complain about the food that were complaining about that". She further stated, "They just plop it on the plate". R33 confirmed the food did not look appetizing and stated although she doesn't care for meat, a sprig of green on the plate would improve the appearance. R33 had a BIMS score on 1/22/14 of 15/15 which indicated she was cognitively intact. During and interview on 2/25/14 at 9:40 a.m. R45 expressed dissatisfaction with the food served stating, "The food is usually too cold. I ask to have it heated up when we have soup because they serve that barely warm. There could be a lot of improvement in the kitchen." When asked whether the food tasted good he stated, "That is a question I wish you had not asked. They don't make stuff that tastes good. They were supposed to have meatloaf but they served meat balls and they were hard enough to use for a sling shot. The food is overcooked." During an observation of the evening meal the following day on 2/26/14, at 5:45 p.m. R45 stated, "The food is always like this. He stated that a couple weeks ago they said they were having meatloaf so I thought that sounded good so I ordered it. I got meatballs that were so hard you could have shot them in a sling shot. Look at this soup it is so thick there is no broth in it." R45 had	F 364		

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a Brief Interview for Mental Status (BIMS) score on 12/4/13 of 15/15 which indicated he was cognitively intact.

During interview on 2/24/14, at 12:50 p.m. R53 expressed dissatisfaction with the food served stating, "Today at lunch the noodles were cold, the chicken breast was dry with no gravy and the green bean casserole was not good. They will give you your yogurt on a hot plate and your omelet on a cold plate! The food is usually not the right temperature. They keep saying they are working on it but it doesn't change".

During an observation of the supper meal on 2/26/14, at 5:50 p.m. R53 called the surveyor to her table to make note of the open faced tuna melt which was black on the bottom. She stated "And I am expected to eat that"? After the dietary manager was questioned regarding the tuna melt in question, she verified the sandwich should not have been served and proceeded to find an alternative food item for R53.

On 2/27/14, at 9:12 a.m. R53 entered the nursing station and stated that after the burnt tuna sandwich had been returned to the kitchen, "They offered me a grilled cheese which I don't care for but at that point I had been waiting an hour and I thought what the heck, I'll take anything. Then they brought me the grilled cheese and the top was black and the cheese wasn't melted!" When questioned whether an alternative was offered, she was sick of it and just took the top off and ate it. R53 had a BIMS score on 12/25/13 of 15/15 which indicated she was cognitively intact.

When interviewed on 2/25/14, at 10:09 a.m. R65 stated, "The food is very poor quality because it

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F 364	Continued From page 30	F 364		

comes out of a truck, there are very few home made items here. The only good meat is the roast beef, otherwise everything is very tough and dried out. If the meat is chicken, it is dried out, and the vegetables are too overcooked with little flavor. Just watch the meals in the dining room, you will see what I mean. We keep complaining but no one listens to us."

Later, during the noon meal on 2/25/14, at 12:30 p.m. R65 was served broccoli and ham for lunch. R65 stated, "Look at this broccoli, it is overcooked and the ham is tough and dry." It was observed during the noon meal on 2/26/14, that R65 was served pork roast and mixed vegetables with broccoli. R65 stated, "Here it is again, overcooked and dried out, how long does it sit there before we get it? That has to be part of the problem with the overcooking, Please see what you can do about the food here." R65's BIM's score was 15/15, which indicated he was cognitively intact.

During interview on 2/27/14, at 1:11 p.m. the dietary manager (DM) confirmed the tuna melts served the prior evening (2//26/14) were overcooked and indicated the cook "should have started over".

On 2/27/14, at 12:15 p.m. a test tray was obtained and tested by two surveyors. The food was served by cook -A. The food was dished immediately after the last plate was dished and served to the last resident. The menu consisted of: beef with gravy, ham, mashed potatoes, baked potato, mixed vegetables, carrots, ground meat (beef) and ground ham. The ham was noted to taste very dry and the ground ham was dry, straw-like and lukewarm. The ground meat

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F 364	Continued From page 31 was lukewarm and dry. The mixed vegetables were very mushy and the mashed potatoes had very little flavor.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean dietary kitchen, failed to serve food in a manner to prevent cross contamination, failed to monitor milk based supplements for appropriate refrigerator storage and failed to serve foods under sanitary conditions which had the potential to affect all 52 residents who consumed food from the dietary kitchen. Findings include: During the kitchen tour on 2/24/14 at 9:05 a.m. the following observations included: (1) Two metal carts in the kitchen that were splattered with food debris; (2) The cupboard doors throughout the kitchen were be dirty and appeared to have food debris splattered on the outside of the doors;	F 371	F371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY Areas of the kitchen were cleaned and a new cleaning schedule has been instituted. The dietary staff were educated on 3/6/14 & 3/19/14 on the cleaning schedule and the need to maintain sanitary conditions, the proper use of gloves and when to change them, the regulations regarding dating and monitoring dates on perishable items, the need to keep foods covered until ready to serve and the proper temperature requirements for food that is served. The Dietary Manager or her designee will audit the kitchen for proper cleanliness and dating and covering of foods and monitor for proper food temperatures 3 times per week for one month and then weekly for 2 months to ensure understanding and compliance. Results of these audits will be presented at the monthly Quality Assurance Committee and at the Food Committee meetings. Any further action, if necessary will be determined by the interdisciplinary team. Completion Date: 3/20/14	3/20/14

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F 371	Continued From page 32 (3) The chain that used to pull the serving window up and down (which is directly over the serving area) was coated with a thick layer of grease and dust; (4) The tract for the serving window also had grease and dust in the tract; (5) The top shelf of the stove was observed to be caked with dust and grease; (6) Dried food and grease were noted down the sides of the stove and the steamer; and (7) A greasy, dusty cup located on the counter which held 3 food thermometers without covers, were stored with pencils, scissors and markers. The following problems were also noted during the initial kitchen tour on 2/24/14 at 9:10 a.m. and included: (1) In the walk in cooler there was a package of ham dated 2/6/14 in a plastic container. Interview with the dietary aide (DA)-A stated that food was to be thrown after 7 days of opening and that the ham should have been discarded as it had been in the refrigerator 18 days; (2) 3 containers of thawed whipped topping that were thawed and no open date identified on the containers; (3) uncovered slices of pies located on plates in the walk-in cooler; DA-A stated that the pie should not have been in the walk-in uncovered and not dated; (4) 6 cups of pudding located in the walk-in cooler, uncovered and undated; (5) a pack of turkey breast lunch meat that had a manufacturers date of 1/20/14 but not dated when opened and the DA-A did not know how long it had been open. (6) uncovered desserts left in the walk-in cooler from 9:15- 9:45 a.m. during the observation of the walk-in cooler observations.	F 371		

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F 371	Continued From page 33 (7) the refrigerator located near the serving area had 8 glasses of juice uncovered and 4 containers of half and half that were not dated and had a manufacturers stamp of use by 2/24/14 and 16 containers of thawed Hormel Plus 2 (a milk based supplement) without dates to indicate when they were removed from the freezer and thawed. The storage recommendation for the Hormel PLUS - 2 from the company is "Storage Conditions: KEEP FROZEN. Storage After Open: refrigerated. Shelf Life After Open: Up to 14 days @ 34 - 40 degrees." During the evening meal on 2/26/14, beginning at 4:50 p.m. cook- A was observed to take food temperatures. The meal consisted of: beans, squash, tuna melt, vegetable soup, Philly beef sandwiches with shredded cheese and crackers. Cook A retrieved and donned a pair of gloves from her pocket. Cook-A tested the temperature of the 3 containers of vegetable soup with a blue digital thermometer and then proceeded to remove the food thermometer from the dirty cup located on the counter, to verify the reading with the digital thermometer. She wiped only a portion of the thermometer retrieved from the soiled cup and then dropped the thermometer into the soup. Cook -A removed the thermometer with the use of tongs, wiped it with an alcohol wipe and continued to check the temperatures of the other food items. It was noted her gloves were soiled with soup so she removed the soiled gloves and retrieved another pair from her pocket at 5:00 p.m. At this time the dietary manager (CDM) instructed cook-A to wash her hands. Cook-A responded, "why, I had gloves on?" but then washed her hands and donned another pair of	F 371		

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F 371	Continued From page 34 gloves from her pocket. The meal service started at 5:03 p.m. and the following was noted: Cook-A, who was observed to have disposable gloves on both hands, reached out and handled contaminated surfaces which included the outside of the steamer, putting oven mitts on, taking food out of the oven and sorting through resident menu slips. With the same soiled gloves, Cook- A retrieved individual buns out of the package for sandwiches, handled individual cheese slices to place on sandwiches and placed individual saltine crackers on resident plates. At 5:10 Cook-A was observed to continue to serve individual plates of food for residents, picking up individual buns, cheese slices and crackers with there gloved hands. Cook-A was observed to open cupboard doors, steamer lid kitchen drawers and open the refrigerator and microwave, with the same soiled gloved hands. Cook-A was also observed to remove two pieces of bread out of a plastic bag and put the slices in the toaster, with the same soiled gloves. She buttered the toast, opened the oven door, wiped her hand on her shirt and then continued to serve the meal, touching buns, crackers and cheese without changing her gloves. At 5:20 p.m., Cook-A was observed to start to serve individual bowls of the contaminated soup. When questioned if the contaminated soup should be served, she stated "why not." During interview with the CDM on 2/26/14, at 3:45 p.m. she verified that the boxes of Plus 2 were located on the back shelf of the refrigerator and that staff do not date the boxes when removed	F 371		

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F 371	Continued From page 35	F 371		

from the freezer so there was no system to monitor the length of the time the supplements were left in the refrigerator once thawed. CDM verified the milk-based containers should be dated when removed from the freezer, thawed and placed into the refrigerator.

During another interview with the CDM on 2/27/14, at 8:45 a.m. she verified staff need to change gloves between staff and verified the soup should not have been served, but should have been removed from the serving line once the soiled thermometer had been dropped into the food item. She further verified the thermometers should not have been stored in a soiled cup, should not have been utilized to check food temperatures. The CDM was unaware the rationale for using the cup for storage. She also verified that staff would be expected to utilize tongs to serve crackers, the buns and the cheese instead of their hands.

Upon further review of the dirty condition of the kitchen, the CDM verified the presence of dust and grease, dirty carts, soiled stove, soiled steamer, soiled chain above the window and tract (which she stated she had not even noticed and had never been cleaned but should be.) The CDM confirmed she had just started a cleaning schedule. When the surveyor questioned Cook-B regarding the cleaning schedule, she replied, "what cleaning schedule?" Upon discovery of the cleaning schedule it was noted that nothing had been documented and indicated that they were just going to start that schedule.

The facility Policy & Procedure titled Sanitation Gloves revised March 2009, instructs that "Gloves are to be changed as follows: a. Before

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F 371	Continued From page 36 handling "ready to eat" foods. b. When coming in contact with something that is contaminated such as opening a trash can or touching a door knob or faucet. c. After sneezing, coughing or touching the face or hair. d. After coming in contact with body fluids. "	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities related to lack of clinical indications and/or inadequate monitoring, and failed to ensure staff acted on pharmacy recommendations, for 2 of 5 residents (R23 and R48) whose medications were reviewed. Findings include: R23's record was reviewed. R23's active diagnosis from the Minimum Data Set (MDS) form dated 12/10/13, included hypertension, dementia, Parkinson's, anxiety and depression. A Brief Interview for Mental Status (BIMS)	F 428	F428 DRUG REGIMIN REVIEW The drug regimen for Res #23 was reviewed by staff and the PRN Ativan had not been administered since January and the resident no longer required it, so the medication was discontinued by the physician. The physician for Res 46 was contacted regarding the need to evaluate the continued use of Prozac or do a dose reduction and his response was documented. The Consulting Pharmacist was here on 3/13/14 and performed an all facility review and the physicians were notified of all recommendations contained in the report. The professional nursing staff were educated on 3/6/14 on the need to review and notify the physicians of all recommendations. The Director of Nursing or her designee will audit the monthly Consulting Pharmacist report for actions and follow through for the next 3 months. Audit results will be presented at the monthly Quality Assurance Committee meetings and any further action, if necessary will be determined by the interdisciplinary team. Completion Date: 3/20/2014	

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F 428	Continued From page 37 assessment dated 12/10/13, indicated R23 had scored 15/15 and was cognitively intact. Current physician orders indicated Ativan 0.5 milligrams (mg) had been prescribed for anxiety or agitation whenever necessary (PRN) up to two times per day. A review of the December 2013 medication administration record (MAR) indicated R23 had received Ativan 0.5 mg for anxiety during the following times: (1) On 12/5/14, at 6:30 p.m. given for agitation and subsequent documentation revealed "calm/resting" at 7:00 p.m. (2) On 12/11/14, at 2:35 p.m. for general discomfort and the response to the medication was documented at 4:30 p.m. "Resting quietly." (3) On 12/16/13, at 9:15 p.m. with no indication/reason for administration nor effect upon R23 after administration of the medication; (4) On 12/18/13, at 3:00 p.m. with no indication/rationale nor results from receiving the medication; (5) On 12/20/13, at 9:30 p.m. with no indication or rationale for use with no results documented; (6) On 12/27/13, at 2:10 p.m. Ativan given for "c/o (complaints of) general pain/restless" with documentation lacking to indicate the response to the medication; and (7) On 12/30/13, at 9:30 p.m. Ativan administered for anxiety and no resident response to the medication documented. A review of the January 2014 MAR indicated Ativan 0.5 mg had been given on the following dates: (1) On 1/3/14, at 5:30 p.m. administered without an indication for use nor documented resident response; and	F 428		

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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 428	Continued From page 38 (2) On 1/9/14, at 7:30 p.m. administered for anxiety without documentation describing the anxiety symptoms nor whether the resident responded to the medication. Documentation was lacking in the record for R23 related to consistent side effect monitoring for the use of the Ativan. A review of the documentation on the form titled, Monthly Drug Review Documentation was conducted and the pharmacist had recorded "No Problems" on 12/12/13, 1/13/14 and 2/12/14, indicating no drug problems had been identified for R23. The form was signed by the consultant pharmacist. During interview with the consultant pharmacist on 2/27/14, at 8:40 a.m., the pharmacist verified R23's use of Ativan had not been addressed in the pharmacy reviews for December 2013, January 2014 or February 2014. During interview with the director of nursing on 2/27/14, at 9:30 a.m., the DON verified there had been no recommendations from the pharmacist regarding R23's intermittent use of the medication Ativan without adequate indications for use and/or monitoring of the medication's effectiveness. R46's record was reviewed and the face sheet indicated the resident had been admitted on 5/3/11 with diagnoses including depression. The physician orders indicated R46 had been restarted on Prozac 10 mg (milligrams) po (by mouth) daily on 2/25/13. Review of the Behavior-Medication monitoring form from the consulting pharmacist, dated 8/10/13, included: "Six month drug re-evaluation	F 428		

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MAR 27 2014
Minnestoa Department of Health
Marshall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING ______ B. WING ______	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 428	Continued From page 39 is due for: Prozac 10 mg daily. Please document dose response observed for controlling target depressive/dementia symptoms or attempt dose reduction if no longer needed". The form lacked documentation of response from either the nursing staff or the physician. During interview on 2/27/14, at 1:45 p.m. the director of nursing (DON) confirmed the physician had not attempted a GDR or provided rationale as why R46 should continue on the medication Prozac since starting the medication on 2/25/14. The DON confirmed the Behavior-Medication monitoring form dated 8/10/13 from the pharmacist had not been communicated to the physician for review of the pharmacy recommendation.	F 428		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the floor tiles in 4 of 4 resident hallways (100, 200, 300 and 400 wings) in a safe and sanitary manner; and failed to replace stained ceiling tiles in 2 of 4 resident hallways (200 and 400 wings). Findings include: During an environmental tour with the	F 465		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING ______ B. WING ______	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 465	Continued From page 40 administrator and director of environmental services (DES) at 2:00 p.m. on 2/27/14, the following observations were made: There were areas the length of the resident hallways observed to be stained and to have a build up of wax. The floor tiles were observed to be 12 inch square white tiles. Numerous floor tiles throughout the four hallways had become discolored to grayish, charcoal and/or black in color. The discolored areas were noted to be present in long strips throughout the halls. The 100 wing, 200 wing and 300 wing floors were observed during the environmental tour to have sections of cracked tiles the width of the hallways. At the entrance of the wing, approximately a third of the way down the hallway was another crack that spread across 5 floor tiles. At the entrance of the 400 wing, one section of cracked tiles were observed. The administrator stated during the tour that the cracks could be from the building settling/shifting or just normal wear and tear. The ceiling tiles down the 200 and 400 wings were observed to have numerous large stained areas present. Some of the tiles appeared discolored a dark tan/gray color and others had a blackish discoloration. The administrator verified during the tour, the ceiling tiles should be changed. When interviewed on 2/27/14, at 2:30 p.m. the administrator and DES were not sure of the cause for the discolored areas on the floor tiles. The floor care personnel, (FCP)-B was interviewed at that same time and described the process for waxing the floors. FCP-B said the	F 465	F465 FUNCTIONAL SANITARY COMFORTABLE ENVIRONMENT The facility has custodial procedures in place for care of floors and ceilings. In the past 2 years new flooring, Teknoflor in all resident room, bathrooms, resident dining rooms and dining corridor; Ceramic Daltile in resident tub and shower rooms, and public rest rooms; new Shaw carpeting in the sunroom, family dining room, therapy room, chapel, and administrative office wing and entry. New floor tile has been ordered and installed in the four corridor wings identified where some settling and cracking has occurred. All four corridors will wings have been stripped and rewaxed. The four stained ceiling tiles have been replaced as well. Floors and ceilings will be routinely checked by Maintenance and cleaned, waxed or replaced as needed. This will be monitored by the Environmental Services Director and/ or his designee and results reported at the monthly Quality Assurance Committee meetings. Any further action, if needed will be determined by the interdisciplinary team. Completion Date: 3/20/2014	3/20/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING ____ B. WING ____	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	**745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159**

(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 465	Continued From page 41 floors were waxed in "strips" so staff could provide care to residents who lived down the halls. FCP-B further stated staff did not routinely strip of the original wax prior to application of a fresh wax. FCP-B said the staff utilized a new product called "GP Forward" which did not remove the old wax very well. The DES verified the old wax build up had not been stripped from the floors.	F 465		

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

F5549023

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 25, 2014. At the time of this survey, Building 01 of Good Samaritan Society Mountain Lake was found not to be 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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 55101-5145, or	K 000	POC ok 3-31-14 	

Exit: 3-27-14 Doc: 4-8-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 3/25/14

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
	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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	K 000		

By eMail 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.

Building 01 of Good Samaritan Society Mountain Lake was constructed as follows:
The original building was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction;
The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction;
The 2000 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 53 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, one set of double doors located on the 400 Wing egress corridor failed to positively latch into its frame. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.6.3. In a fire emergency, this deficient practice could adversely affect 20 of 55 residents, staff and visitors. FINDINGS INCLUDE: On 02/25/2014 at 11:10 AM, observation revealed a set of side-hinged double doors leading into the Linen Storage Room on the 400- Wing corridor.	K 018	**K 018 DOOR OPENINGS** **The manual flush bolt on the inactive door leaf of the linen storage room has been replaced with automatic spring latches to assure the doors are positively latching when closed. Ongoing compliance will be monitored by the Director of Environmental Services and/or his designee. Results will be presented at the monthly Quality Assurance Committee meetings and any further action, if necessary will be determined by the interdisciplinary team.** Completion Date: 3/27/14	3/27/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 018	Continued From page 3 When closed, these doors did not positively latch, as the manual flush bolts on the inactive door leaf had not been activated. This finding was confirmed with the chief building engineer at the time of discovery.	K 018		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based upon a review of available documentation, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 55 of 55 residents, staff and visitors. FINDINGS INCLUDE: On 02/25/2014 at 10:30 AM, during a review of the facility's annual fire alarm inspection & test report dated 02/11/2014, eleven (11) manual fire	K 052	K 052 FIRE ALARM MAINTENANCE The proper documentation missing at the time of the survey was subsequently received from the alarm monitoring vendor who routinely performs the annual fire alarm inspection and test. This document has been added to the files. The Director of Environmental Services and/or his designee will monitor that proper documentation is received annually as required and will verify that it includes identifying the location and outcome for both visual and functional test results of each alarm initiating device. Results of this monitoring will be presented at the monthly Quality Assurance Committee meeting for review and any further action, if necessary will be determined by the interdisciplinary team. Completion Date: 3/3/2014	3/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 052	Continued From page 4 alarm boxes and thirty-seven (37) room smoke detectors were noted on the system, however, no documentation was provided identifying the locations and outcomes for both visual and functional test results for each of these Alarm Initiating Devices. As such, it could not be verified that visual and functional testing of each device on the fire alarm system had been properly conducted. This finding was confirmed with the chief building engineer.	K 052		

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

F5549023

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2013 LINK ADDITION B. WING	(X3) DATE SURVEY COMPLETED 02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 25, 2014. At the time of this survey, Building 02 of Good Samaritan Society Mountain Lake was found not to be 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) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

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 55101-5145, or

POC ok 3/31/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/25/14

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
	245549	A. BUILDING 02 - 2013 LINK ADDITION B. WING ______	02/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 By eMail 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. Building 02 of Good Samaritan Society Mountain Lake consists of the 2013 Link Addition. It is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. There are no resident sleeping or treatment areas located in Building 02. Building 02 is separated from an assisted living facility by a proper two-hour fire wall assembly. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 53 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING **02 - 2013 LINK ADDITION** B. WING ______	**02/25/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	**745 BASINGER MEMORIAL DRIVE** **MOUNTAIN LAKE, MN 56159**

(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 052	Continued From page 2	K 052		

A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

This STANDARD is not met as evidenced by:
Based upon a review of available documentation, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 18, Section 18.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. In a fire emergency, this deficient practice could adversely affect 55 of 55 residents, staff and visitors.

FINDINGS INCLUDE:

On 02/25/2014 at 10:30 AM, during a review of the facility's annual fire alarm inspection & test report dated 02/11/2014, eleven (11) manual fire alarm boxes and thirty-seven (37) room smoke detectors were noted on the system, however, no documentation was provided identifying the locations and outcomes for both visual and functional test results for each of these Alarm Initiating Devices. As such, it could not be verified that visual and functional testing of each device on the fire alarm system had been properly conducted.

This finding was confirmed with the chief building engineer.

K 052 FIRE ALARM MAINTENANCE
The proper documentation missing at the time of the survey was subsequently received from the alarm monitoring vendor who routinely performs the annual fire alarm inspection and test. This document has been added to the files. The Director of Environmental Services and/or his designee will monitor that proper documentation is received annually as required and will verify that it includes identifying the location and outcome for both visual and functional test results of each alarm initiating device. Results of this monitoring will be presented at the monthly Quality Assurance Committee meeting for review and any further action, if necessary will be determined by the interdisciplinary team.
Completion Date: 3/3/2014

3/3/14

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7890

March 14, 2014

Mr. Tim Swoboda, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, Minnesota 56159

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5549024

Dear Mr. Swoboda:

The above facility was surveyed on February 24, 2014 through February 27, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health at:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street Marshall, MN 56258
Office: (507) 537-7158 Fax: (507) 537-7194

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00755	A. BUILDING: ______ B. WING ______	02/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAK	**745 BASINGER MEMORIAL DRIVE** **MOUNTAIN LAKE, MN 56159**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On February 24nd, 25nd, 26th and 27th, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, 1400 E. Lyon Street, Marshall, Minnesota 56258.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		

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2 565	Continued From page 2	2 565		

by:
Based on observation, interview and document review, the facility failed to provide oral hygiene as defined in the plan of care for 1 of 3 residents (R4) reviewed who were dependent upon staff for oral hygiene.

Findings include:

R4's medical record was reviewed. The care plan dated 2/26/14, indicated R4 had a problem of self care deficit related to weakness and limited mobility, and interventions included the need for total assist with oral care twice daily.

In addition, review of the face sheet in the record indicated R4 had admission diagnoses which included multiple sclerosis and neuropathy. The quarterly Minimum Data Set (MDS) dated 11/27/13, identified that R4 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. The MDS also identified R4 as needing total assist from staff with grooming.

During observation on 2/25/14, at 11:06 a.m. it was noted that R4 had no upper teeth and the bottom teeth appeared dirty with debris. R4 stated during interview at that time that staff do not brush her teeth daily. R4 said the staff brush her teeth maybe once a week and further reported that staff had not brushed her teeth the previous evening or that morning during cares.

During observation on 2/26/14, at 1:48 p.m. R4's lower teeth had what appeared to be a build-up of white material. R4 stated her teeth had not been brushed "last night or this morning."

During interview with R4 on 2/27/14 at 9:00 a.m.,

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2 565		2 565		

Continued From page 3

R4 stated her teeth were not brushed the prior evening during cares. R4 stated NA-A was "a good one" and that she brushed her teeth when cares were provided. R4 again stated, "they might brush them once a week" (reference to other staff).

During interview with NA-A on 2/27/14, at 9:30 a.m., NA-A stated she always brushes R4's teeth when cares are provided. However, NA-A stated she doesn't work with R4 that often.

During interview with registered nurse (RN)-A on 2/27/14, at 8:53 a.m., RN-A verified the NAs were expected to provide oral cares during morning and evening cares. RN-A confirmed that R4 was cognitively intact and could accurately report whether or not staff had brushed her teeth as defined on the plan of care.

During interview with the director of nursing (DON) on 2/27/14, at 10:05 a.m. she stated the expectation was that staff would follow the resident's care plan and provide oral care both in the morning and the evening. The DON also verified that R4 was cognitively intact and would be accurate in reporting whether oral cares had been provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing could re-educate all staff to follow care plans in regards to specific resident cares and services, and could develop a system to audit and monitor for compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 855	Continued From page 4	2 855		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services to maintain oral hygiene for 1 of 3 residents (R4) reviewed who was dependent upon staff for oral hygiene. Findings include: R4's medical record was reviewed. The face sheet indicated R4 had admission diagnoses which included multiple sclerosis and neuropathy. The quarterly Minimum Data Set (MDS) dated 11/27/13, identified that R4 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. The MDS also identified R4 as needing total assist from staff with grooming. The care plan dated 2/26/14, indicated R4 had a problem of self care deficit related to weakness and limited mobility, and the interventions included the need for total assist with oral care twice daily. During observation on 2/25/14, at 11:06 a.m. it was noted that R4 had no upper teeth and the bottom teeth appeared dirty with debris. R4 stated during interview at that time that staff do	2 855		

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2 855	Continued From page 5	2 855		

not brush her teeth daily. R4 said the staff brush her teeth maybe once a week and further reported that staff had not brushed her teeth the previous evening or that morning during cares.

During observation on 2/26/14, at 1:48 p.m. R4's lower teeth had what appeared to be a build-up of white material. R4 stated her teeth had not been brushed "last night or this morning."

During observation on 2/27/14 at 8:16 a.m., nursing assistant (NA)- A was observed providing morning cares for R4. NA-A was observed to brush R4's teeth.

During additional interview with R4 on 2/27/14 at 9:00 a.m., R4 stated her teeth were not brushed the prior evening during cares. R4 stated NA-A was "a good one" and that she brushed her teeth when cares were provided. R4 again stated, "they might brush them once a week" (reference to other staff).

During interview with NA-A on 2/27/14, at 9:30 a.m., NA-A stated she always brushes R4's teeth when cares are provided. However, NA-A stated she doesn't work with R4 that often.

During interview with registered nurse (RN)-A on 2/27/14, at 8:53 a.m., RN-A verified the NAs were expected to provide oral cares during morning and evening cares. RN-A confirmed that R4 was cognitively intact and could accurately report whether or not staff had brushed her teeth as defined on the plan of care.

During interview with the director of nursing (DON) on 2/27/14, at 10:05 a.m. she stated the expectation was that staff would follow the resident's care plan and provide oral care both in

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2 855	Continued From page 6	2 855		

the morning and the evening. The DON also verified that R4 was cognitively intact and would be accurate in reporting whether oral cares had been provided.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review policy and provide education for staff regarding providing oral hygiene to residents requiring physical assistance with tooth brushing. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

2 960 — MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality — **2 960**

Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food.

This MN Requirement is not met as evidenced by:
Based on observation and interview the facility failed to provide meals that are palatable and attractive for 7 of 52 residents (R10, R13, R33, R31, R45, R53 & R65) who were served meals.

Findings include:

During interview on 2/25/14, at 10:14 a.m. R10 expressed dissatisfaction with the food served at the facility stating, "It's edible; sometimes it's very good and sometimes it's very poor". During subsequent observation/interview on 2/27/14, at

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2 960	Continued From page 7	2 960		

11:45 a.m. R10 stated the tomato soup she was served for supper on 2/26/14 was "not very good". R10 further stated she sent back the tuna melt sandwich that was served as it was burnt. Documentation on the Brief Interview for Mental Status (BIMS), dated 2/13/15 indicated R10 was cognitively intact and had a score of 15/15.

When questioned about the meal on 2/25/14 at 5:39 p.m., R13 was unable to identify the meat she had been eating and stated, "I don't know what this is, I really don't, it is so dry."
R13 had a BIMS score on 11/27/13, of 15/15 which indicated cognitively intact.

During interview on 2/26/14, at 5:44 p.m. R31 stated the food served "isn't very good". While R31 awaited her meal, she pointed at her tablemate's (R51) sandwich and stated, "I hope mine's not like that". The bread on R51's tuna melt sandwich was noted to be a dark brown to black in color and appeared burnt. R31 indicated that one day when the planned meal was supposed to be meatloaf, meatballs were served instead, "and they were burnt". R31 further stated she had been served soup recently that had so much pepper seasoning added that "It burnt my throat going all the way down".

During a subsequent interview on 2/27/14, at 11:45 a.m. R31 stated that when her meal was finally served the night before, she received tomato soup which she sent back to the dietary department, stating, "I can't eat tomato soup". R31 was offered minestrone soup which she declined and then staff found a can of vegetable soup and that was "ok". R31 had a BIMS score on 1/16/14 of 15/15 indicating she was cognitively intact.

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2 960	Continued From page 8 During interview on 2/26/14, at 2:30 p.m. R33 stated, "The food isn't very good here". R33 further stated the timeliness of food service, the quality of the food and the temperature of the food being too cold was an issue as well. R33 indicated that about a month ago the residents were served meatballs that tasted like they had been "taken off of some leftover spaghetti; there were people who usually don't complain about the food that were complaining about that". She further stated, "They just plop it on the plate". R33 confirmed the food did not look appetizing and stated although she doesn't care for meat, a sprig of green on the plate would improve the appearance. R33 had a BIMS score on 1/22/14 of 15/15 which indicated cognitive intact. During and interview on 2/25/14 at 9:40 a.m. R45 expressed dissatisfaction with the food served stating, "The food is usually too cold. I ask to have it heated up when we have soup because they serve that barely warm. There could be a lot of improvement in the kitchen." When asked whether the food tasted good he stated, "That is a question I wish you had not asked. They don't make stuff that tastes good. They were supposed to have meatloaf but they served meat balls and they were hard enough to use for a sling shot. The food is overcooked." During an observation of the evening meal the following day on 2/26/14, at 5:45 p.m. R45 stated, "The food is always like this. He stated that a couple weeks ago they said they were having meatloaf so I thought that sounded good so I ordered it. I got meatballs that were so hard you could have shot them in a sling shot. Look at this soup it is so thick there is no broth in it." R45 had a Brief Interview for Mental Status (BIMS) score	2 960		

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2 960	Continued From page 9	2 960		

on 12/4/13 of 15/15 which indicated he was cognitively intact.

During interview on 2/24/14, at 12:50 p.m. R53 expressed dissatisfaction with the food served stating, "Today at lunch the noodles were cold, the chicken breast was dry with no gravy and the green bean casserole was not good. They will give you your yogurt on a hot plate and your omelet on a cold plate! The food is usually not the right temperature. They keep saying they are working on it but it doesn't change".

During an observation of the supper meal on 2/26/14, at 5:50 p.m. R53 called the surveyor to her table to make note of the open faced tuna melt which was black on the bottom. She stated "And I am expected to eat that"? After the dietary manager was questioned regarding the tuna melt in question, she verified the sandwich should not have been served and proceeded to find an alternative food item for R53.

On 2/27/14, at 9:12 a.m. R53 entered the nursing station and stated that after the burnt tuna sandwich had been returned to the kitchen, "They offered me a grilled cheese which I don't care for but at that point I had been waiting an hour and I thought what the heck, I'll take anything. Then they brought me the grilled cheese and the top was black and the cheese wasn't melted!" When questioned whether an alternative was offered, she was sick of it and just took the top off and ate it. R53 had a BIMS score on 12/25/13 of 15/15 which indicated she was cognitively intact.

When interviewed on 2/25/14, at 10:09 a.m. R65 stated, "The food is very poor quality because it comes out of a truck, there are very few home made items here. The only good meat is the roast

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2 960	Continued From page 10	2 960		

beef, otherwise everything is very tough and dried out. If the meat is chicken, it is dried out, and the vegetables are too overcooked with little flavor. Just watch the meals in the dining room, you will see what I mean. We keep complaining but no one listens to us."

Later, during the noon meal on 2/25/14, at 12:30 p.m. R65 was served broccoli and ham for lunch. R65 stated, "Look at this broccoli, it is overcooked and the ham is tough and dry." It was observed during the noon meal on 2/26/14, that R65 was served pork roast and mixed vegetables with broccoli. R65 stated, "Here it is again, overcooked and dried out, how long does it sit there before we get it? That has to be part of the problem with the overcooking, Please see what you can do about the food here." R65's BIM's score was 15/15, which indicated he was cognitively intact.

During interview on 2/27/14, at 1:11 p.m. the dietary manager (DM) confirmed the tuna melts served the prior evening (2//26/14) were overcooked and indicated the cook "should have started over".

On 2/27/14, at 12:15 p.m. a test tray was obtained and tested by two surveyors. The food was served by cook -A. The food was dished immediately after the last plate was dished and served to the last resident. The menu consisted of: beef with gravy, ham, mashed potatoes, baked potato, mixed vegetables, carrots, ground meat (beef) and ground ham. The ham was noted to taste very dry and the ground ham was dry, straw-like and lukewarm. The ground meat was lukewarm and dry. The mixed vegetables were very mushy and the mashed potatoes had very little flavor.

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2 960	Continued From page 11 SUGGESTED METHOD FOR CORRECTION: The Director of dietary could review and revise policies and procedures to ensure compliance for nutritive and palatable food. A dining committee could be developed for residents. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 960		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean dietary kitchen, failed to serve food in a manner to prevent cross contamination, failed to monitor milk based supplements for appropriate refrigerator storage and failed to serve foods under sanitary conditions which had the potential to affect all 52 residents who consumed food from the dietary kitchen. Findings include: During the kitchen tour on 2/24/14 at 9:05 a.m. the following observations included: (1) Two metal carts in the kitchen that were splattered with food debris; (2) The cupboard doors throughout the kitchen were be dirty and appeared to have food debris	21015		

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splattered on the outside of the doors;
(3) The chain that used to pull the serving window up and down (which is directly over the serving area) was coated with a thick layer of grease and dust;
(4) The tract for the serving window also had grease and dust in the tract;
(5) The top shelf of the stove was observed to be caked with dust and grease;
(6) Dried food and grease were noted down the sides of the stove and the steamer; and
(7) A greasy, dusty cup located on the counter which held 3 food thermometers without covers, were stored with pencils, scissors and markers.

The following problems were also noted during the initial kitchen tour on 2/24/14 at 9:10 a.m. and included:
(1) In the walk in cooler there was a package of ham dated 2/6/14 in a plastic container. Interview with the dietary aide (DA)-A stated that food was to be thrown after 7 days of opening and that the ham should have been discarded as it had been in the refrigerator 18 days;
(2) 3 containers of thawed whipped topping that were thawed and no open date identified on the containers;
(3) uncovered slices of pies located on plates in the walk-in cooler; DA-A stated that the pie should not have been in the walk-in uncovered and not dated;
(4) 6 cups of pudding located in the walk-in cooler, uncovered and undated;
(5) a pack of turkey breast lunch meat that had a manufacturers date of 1/20/14 but not dated when opened and the DA-A did not know how long it had been open.
(6) uncovered desserts left in the walk-in cooler from 9:15- 9:45 a.m. during the observation of the walk-in cooler observations.

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(7) the refrigerator located near the serving area had 8 glasses of juice uncovered and 4 containers of half and half that were not dated and had a manufacturers stamp of use by 2/24/14 and 16 containers of thawed Hormel Plus 2 (a milk based supplement) without dates to indicate when they were removed from the freezer and thawed.

The storage recommendation for the Hormel PLUS - 2 from the company is "Storage Conditions: KEEP FROZEN. Storage After Open: refrigerated. Shelf Life After Open: Up to 14 days @ 34 - 40 degrees."

During the evening meal on 2/26/14, beginning at 4:50 p.m. cook- A was observed to take food temperatures. The meal consisted of: beans, squash, tuna melt, vegetable soup, Philly beef sandwiches with shredded cheese and crackers. Cook A retrieved and donned a pair of gloves from her pocket. Cook-A tested the temperature of the 3 containers of vegetable soup with a blue digital thermometer and then proceeded to remove the food thermometer from the dirty cup located on the counter, to verify the reading with the digital thermometer. She wiped only a portion of the thermometer retrieved from the soiled cup and then dropped the thermometer into the soup. Cook -A removed the thermometer with the use of tongs, wiped it with an alcohol wipe and continued to check the temperatures of the other food items. It was noted her gloves were soiled with soup so she removed the soiled gloves and retrieved another pair from her pocket at 5:00 p.m. At this time the dietary manager (CDM) instructed cook-A to wash her hands. Cook-A responded, "why, I had gloves on?" but then washed her hands and donned another pair of gloves from her pocket.

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21015	Continued From page 14 The meal service started at 5:03 p.m. and the following was noted: Cook-A, who was observed to have disposable gloves on both hands, reached out and handled contaminated surfaces which included the outside of the steamer, putting oven mitts on, taking food out of the oven and sorting through resident menu slips. With the same soiled gloves, Cook- A retrieved individual buns out of the package for sandwiches, handled individual cheese slices to place on sandwiches and placed individual saltine crackers on resident plates. At 5:10 Cook-A was observed to continue to serve individual plates of food for residents, picking up individual buns, cheese slices and crackers with there gloved hands. Cook-A was observed to open cupboard doors, steamer lid kitchen drawers and open the refrigerator and microwave, with the same soiled gloved hands. Cook-A was also observed to remove two pieces of bread out of a plastic bag and put the slices in the toaster, with the same soiled gloves. She buttered the toast, opened the oven door, wiped her hand on her shirt and then continued to serve the meal, touching buns, crackers and cheese without changing her gloves. At 5:20 p.m., Cook-A was observed to start to serve individual bowls of the contaminated soup. When questioned if the contaminated soup should be served, she stated "why not." During interview with the CDM on 2/26/14, at 3:45 p.m. she verified that the boxes of Plus 2 were located on the back shelf of the refrigerator and that staff do not date the boxes when removed from the freezer so there was no system to monitor the length of the time the supplements	21015		

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were left in the refrigerator once thawed. CDM verified the milk-based containers should be dated when removed from the freezer, thawed and placed into the refrigerator.

During another interview with the CDM on 2/27/14, at 8:45 a.m. she verified staff need to change gloves between staff and verified the soup should not have been served, but should have been removed from the serving line once the soiled thermometer had been dropped into the food item. She further verified the thermometers should not have been stored in a soiled cup, should not have been utilized to check food temperatures. The CDM was unaware the rationale for using the cup for storage. She also verified that staff would be expected to utilize tongs to serve crackers, the buns and the cheese instead of their hands.

Upon further review of the dirty condition of the kitchen, the CDM verified the presence of dust and grease, dirty carts, soiled stove, soiled steamer, soiled chain above the window and tract (which she stated she had not even noticed and had never been cleaned but should be.) The CDM confirmed she had just started a cleaning schedule. When the surveyor questioned Cook-B regarding the cleaning schedule, she replied, "what cleaning schedule?" Upon discovery of the cleaning schedule it was noted that nothing had been documented and indicated that they were just going to start that schedule.

The facility Policy & Procedure titled, Sanitation Gloves revised March 2009, instructs that "Gloves are to be changed as follows: a. Before handling "ready to eat" foods. b. When coming in contact with something that is contaminated such as opening a trash can or touching a door knob or

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	faucet. c. After sneezing, coughing or touching the face or hair. d. After coming in contact with body fluids. "			
	SUGGESTED METHOD FOR CORRECTION: The Administrator and the Dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis.			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days.			
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control	21426		
	(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.			
	(b) Written compliance with this subdivision must be maintained by the nursing home.			

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This MN Requirement is not met as evidenced by:
Based on interview and document review the facility failed to administer a two step tuberculin skin test (TST) for 1 of 5 residents (R72) reviewed for infection control.

Findings include:

R72 was admitted to the facility on 1/7/14. Review of the immunization record indicated R72 received a first step tuberculin skin test on 1/7/14 and was read on 1/10/14 with a negative result of 0 millimeters (mm) induration. The record did not indicate that a 2nd step TST had been completed.

During interview on 2/27/14 at 1:40 p.m. the director of nursing (DON) confirmed that starting January 2014 and since that time, the facility had not had a shortage of Mantoux (TST) solution.

During interview on 2/27/14 at 3:12 p.m. registered nurse (RN)-A confirmed that a 2nd step TST was not administered to R72.

The facility procedure titled Screening of Residents for Tuberculosis revised 11/13 includes: "A two-step Mantoux method should be used for TST when testing in the care center. This involves administering the initial test upon admission, which is read within 48 to 72 hours by a nursing professional or physician. If the first TST is negative, the second test should be placed one to three weeks after the placement of the first test. The second test is read 48 to 72 hours after administration."

SUGGESTED METHOD OF CORRECTION:

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21426	Continued From page 18 The director of nursing or her designee could development and implement policies and procedures for tuberculosis screening per the Center for Disease Control recommendations. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must	21530		

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refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities related to lack of clinical indications and/or inadequate monitoring, and failed to ensure staff acted on pharmacy recommendations, for 2 of 5 residents (R23 and R48) whose medications were reviewed.

Findings include:

R23's record was reviewed. R23's active diagnosis from the Minimum Data Set (MDS) form dated 12/10/13, included hypertension, dementia, Parkinson's, anxiety and depression. A Brief Interview for Mental Status (BIMS) assessment dated 12/10/13, indicated R23 had scored 15/15 and was cognitively intact. Current physician orders indicated Ativan 0.5 milligrams (mg) had been prescribed for anxiety or agitation whenever necessary (PRN) up to two times per day.

A review of the December 2013 medication administration record (MAR) indicated R23 had

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received Ativan 0.5 mg for anxiety during the following times:
(1) On 12/5/14, at 6:30 p.m. given for agitation and subsequent documentation revealed "calm/resting" at 7:00 p.m.
(2) On 12/11/14, at 2:35 p.m. for general discomfort and the response to the medication was documented at 4:30 p.m. "Resting quietly."
(3) On 12/16/13, at 9:15 p.m. with no indication/reason for administration nor effect upon R23 after administration of the medication;
(4) On 12/18/13, at 3:00 p.m. with no indication/rationale nor results from receiving the medication;
(5) On 12/20/13, at 9:30 p.m. with no indication or rationale for use with no results documented;
(6) On 12/27/13, at 2:10 p.m. Ativan given for "c/o (complaints of) general pain/restless" with documentation lacking to indicate the response to the medication; and
(7) On 12/30/13, at 9:30 p.m. Ativan administered for anxiety and no resident response to the medication documented.

A review of the January 2014 MAR indicated Ativan 0.5 mg had been given on the following dates:
(1) On 1/3/14, at 5:30 p.m. administered without an indication for use nor documented resident response; and
(2) On 1/9/14, at 7:30 p.m. administered for anxiety without documentation describing the anxiety symptoms nor whether the resident responded to the medication.

Documentation was lacking in the record for R23 related to consistent side effect monitoring for the use of the Ativan.

A review of the documentation on the form titled,

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Monthly Drug Review Documentation was conducted and the pharmacist had recorded "No Problems" on 12/12/13, 1/13/14 and 2/12/14, indicating no drug problems had been identified for R23. The form was signed by the consultant pharmacist. During interview with the consultant pharmacist on 2/27/14, at 8:40 a.m., the pharmacist verified R23's use of Ativan had not been addressed in the pharmacy reviews for December 2013, January 2014 or February 2014.

During interview with the director of nursing on 2/27/14, at 9:30 a.m., the DON verified there had been no recommendations from the pharmacist regarding R23's intermittent use of the medication Ativan without adequate indications for use and/or monitoring of the medication's effectiveness.

R46's record was reviewed and the face sheet indicated the resident had been admitted on 5/3/11 with diagnoses including depression. The physician orders indicated R46 had been restarted on Prozac 10 mg (milligrams) po (by mouth) daily on 2/25/13.

Review of the Behavior-Medication monitoring form from the consulting pharmacist, dated 8/10/13, included: "Six month drug re-evaluation is due for: Prozac 10 mg daily. Please document dose response observed for controlling target depressive/dementia symptoms or attempt dose reduction if no longer needed". The form lacked documentation of response from either the nursing staff or the physician.

During interview on 2/27/14, at 1:45 p.m. the director of nursing (DON) confirmed the physician had not attempted a GDR or provided rationale as why R46 should continue on the medication

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21530	Continued From page 22 Prozac since starting the medication on 2/25/14. The DON confirmed the Behavior-Medication monitoring form dated 8/10/13 from the pharmacist had not been communicated to the physician for review of the pharmacy recommendation. SUGGESTED METHOD OF CORRECTION: The pharmacist and/or director of nursing could in-service and monitor for compliance with maintaining a functional and safe pharmaceuticals services for the residents and ensure monthly regimen reviews are completed. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If	21540		

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21540	Continued From page 23 the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 2 of 5 residents' (R46 and R23) drug regimens were free from unnecessary medications. The facility staff failed to attempt a gradual dose reduction (GDR) of an antidepressant medication, failed to provide rationale for continued usage, and failed to ensure adequate monitoring was conducted for the use of an antianxiety medication. Findings include: R46's record was reviewed and the face sheet indicated the resident had been admitted on 5/3/11 with diagnoses including depression. The physician orders indicated R46 had been restarted on Prozac 10 mg (milligrams) po (by mouth) daily on 2/25/13. Review of the quarterly Patient Health Questionnaire (PHQ-9)- a tool used to determine potential mood problems dated 12/11/13, indicated that R46 scored a zero (0) indicating no sign/symptoms related to depression. Review of R46's care plan dated 12/18/13 identified R46 had an alteration in mood and behavior related to episodes of withdrawal, anxiety, and increased confusion as evidenced by complaints of not feeling well and tearfulness. Care plan approaches reviewed from 8/31/13 through 2/25/14, indicated R46 had no episodes of tearfulness or general physical complaints during this time frame.	21540		

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21540	Continued From page 24 Review of the Behavior-Medication monitoring form from the consulting pharmacist, dated 8/10/13, included: "Six month drug re-evaluation is due for: Prozac 10 mg daily. Please document dose response observed for controlling target depressive/dementia symptoms or attempt dose reduction if no longer needed". The form lacked documentation of response from either the nursing staff or the physician. During interview on 2/27/14, at 1:45 p.m. the director of nursing (DON) confirmed the physician had not attempted a GDR or provided rationale as why R46 should continue on the medication Prozac since starting the medication on 2/25/14. The DON confirmed the Behavior-Medication monitoring form dated 8/10/13 from the pharmacist had not been communicated to the physician for review of the pharmacy recommendation. R23's record was reviewed. The medication administration record (MAR) indicated R23 had received Ativan 0.5 mg (antianxiety) on 12/16/13, at 9:15 p.m. and had experienced a fall on 12/17/13, at 12:35 a.m. (3 hours, 20 minutes later). In addition, the MAR indicated R23 had received Ativan 0.5 mg on 12/30/13 at 9:30 p.m., and had experienced another fall on 12/31/13, at 1:10 a.m. (3 hours & 50 minutes later). R23's active diagnosis from the Minimum Data Set (MDS) form dated 12/10/13, included hypertension, dementia, Parkinson's, anxiety and depression. This MDS further indicated R23 had a history of falls having occurred 2-6 months prior to admission. A Brief Interview for Mental Status (BIMS) assessment dated 12/10/13, indicated R23 had scored 15/15 and was cognitively intact.	21540		

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R23's current care plan dated 12/19/13 included; "Comfort: Alteration in R/T (related to) DJD (degenerative joint disease) of lumbar spine; chronic low back pain w/ (with) hx (history) of being difficult to manage." Approaches included; "Yelling at staff: often does this when having sig (significant) pain; notify nurse". In addition the care plan included; "Mood/behavior; Alteration in R/T depression, anxiety, dementia, and pain, history of being combative, shouting at and berating staff prior to admission here, also calls out when experiencing pain." Approaches included; " Explain purpose of your visit as well as cares and procedures, esp (especially) when anxious or experiencing pain. X/(example) behavior; calls out or hollers, inquire about res pain level and report to nurse." The communication section of the plan of care included: "Deficit in cognitive changes R/T dementia; also has a history of confusion, agitation, anxiety with increased pain level causing difficulty with comprehension." R23's plan of care addressed the potential for adverse consequences R/T current medication regime and directed the staff to monitor for adverse consequences of all medications.

A review of the documentation on the form titled, Monthly Drug Review Documentation was conducted and the pharmacist had recorded "No Problems" on 12/12/13, 1/13/14 and 2/12/14, indicating no drug problems had been identified for R23. The form was signed by the consultant pharmacist.

Physician orders indicated Ativan 0.5 milligrams (mg) was prescribed for anxiety or agitation whenever necessary (PRN) up to two times per day.

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According to WebMD, Ativan/Lorazepam is a drug used to treat anxiety. The WebMD site included, "Older adults may be more sensitive to the side effects of this drug, especially loss of coordination and drowsiness. Also, the elderly may not experience the relief of anxiety with lorazepam. It may have the opposite effect on the elderly, causing symptoms including mental/mood changes, sleeping problems, increase in sexual interest, or hallucinations. Loss of coordination drowsiness and sleeping problems may increase the risk of falling."

A review of the December 2013 MAR indicated R23 had received Ativan 0.5 mg for anxiety during the following times:
(1) On 12/5/14, at 6:30 p.m. given for agitation and subsequent documentation revealed "calm/resting" at 7:00 p.m.
(2) On 12/11/14, at 2:35 p.m. for general discomfort and the response to the medication was documented at 4:30 p.m. "Resting quietly."
(3) On 12/16/13, at 9:15 p.m. with no indication/reason for administration nor effect upon R23 after administration of the medication;
(4) On 12/18/13, at 3:00 p.m. with no indication/rationale nor results from receiving the medication;
(5) On 12/20/13, at 9:30 p.m. with no indication or rationale for use with no results documented;
(6) On 12/27/13, at 2:10 p.m. Ativan given for "c/o (complaints of) general pain/restless" with documentation lacking to indicate the response to the medication; and
(7) On 12/30/13, at 9:30 p.m. Ativan administered for anxiety and no resident response to the medication documented.

A review of the January 2014 MAR indicated

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21540	Continued From page 27 Ativan 0.5 mg had been given on the following dates: (1) On 1/3/14, at 5:30 p.m. administered without an indication for use nor documented resident response; and (2) On 1/9/14, at 7:30 p.m. administered for anxiety without documentation describing the anxiety symptoms nor whether the resident responded to the medication. Documentation was lacking in the record for R23 related to consistent side effect monitoring for the use of the Ativan. During interview with the consultant pharmacist on 2/27/14, at 8:40 a.m., the pharmacist verified R23's use of Ativan was not addressed in the pharmacy review for December 2013, January 2014 or February 2014. During interview with the director of nursing on 2/27/14, at 9:30 a.m., the DON verified there had been no recommendations from the pharmacist regarding R23's intermittent use of the medication Ativan without adequate indications for use and/or monitoring of the medication's effectiveness. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the use of psychoactive medications with the licensed staff to meet the requirements of the state and federal regulations. A quality assurance audit could be implemented to ensure that psychoactive medications are monitored and reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		

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21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the environment was maintained in a comfortable manner by ensuring odors were addressed for 2 of 2 resident rooms (R13 & R48) that had a strong urine odor present throughout the survey and failed to ensure that hot water temperatures in resident bathrooms (R3, R13, R22, R36, R42, R43, R48, R65 and R102) were maintained within a safe range and this had the potential to affect 9 of 16 resident bathrooms checked for hot water temperatures. . Findings include: Throughout each day of the survey 2/24, 2/25, 2/26 and 2/27/14, there was a strong urine odor observed to be present in R13 and R48's bedrooms and bathrooms. R13's record was reviewed. According to a Brief Interview for Mental Status (BIMS) assessment completed on 11/22/13, R13 had a score of 15/15 which indicated the resident's cognition was intact and the resident was interviewable. R13 was not aware of the urine odor smell in the room but did verify she would not want visitors in the room with a strong urine odor. Although the administrator indicated the urine odor could have originated	21665		

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with the resident's personal chair located in the room, he was unaware if an attempt had been made to clean personal chairs and/or if the origin of the smell had been determined. It was noted the urine odor was also present in the bathroom.

When interviewed on 2/26/14, at 1:00 p.m. nursing assistant (NA)-D stated, " They have tried to cover it up [the urine odor] with spray but it still smells. They have told us to just spray the room to cover the smell." NA-D showed the surveyor the product utilized to spray in the room. The label on the product indicated it was called, Tuscan garden odor counteractant.

During interview with the director of nursing (DON) at 1:15 p.m. on 2/26/14, the DON verified administration was aware of the odor in R13's room and stated, "It has been a problem since she [R13] came here."

During an environmental tour with the administrator and director of environmental services (DES) on 2/27/14 at 2:30 p.m., a strong urine odor was observed in R48's room. The odor was also noticed in the hallway. During the tour the administrator and DES verified the odor. The DES said the facility did not have a policy for urine odor control.

R48's record was reviewed. According to the record, R48 had been assessed to have severe cognitive impairment as not able to be interviewed.

During an interview with the DON on 2/27/14, at 2:00 p.m., the DON stated the urine odor present in R48's room could be due to the resident's use of an urinary catheter, but agreed that odor control should be addressed.

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During the environmental tour on 2/27/14, at 9:30 a.m. with the administrator and director of environmental services, water temperatures were checked in a variety of resident bathrooms on each wing at the beginning of the wing and the end of the wing and on each side of the wing.

Temperatures were record as Fahrenheit and noted in the following areas:
(1) Resident 100 wing: R102-123 degrees, R43-122 degrees, R48-124 degrees;
(2) Resident 200 wing: R3- 123 degrees, R13-124 degrees, R22- 122 degrees, R36- 122 degrees; and
(3) Resident 300 wing: R42-125 degrees and R65-123 degrees.

Interview with the administrator and director of maintenance on 2/27/13, at 9:30 a.m. verified the recommended state temperatures can go up to 115 degrees for domestic water. The director of maintenance shared that the facility had a new hot water heater installed and stated, "A couple of weeks ago, maybe a month since the hot water heater was put in." The director of maintenance verified the water temperatures had not been checked since the new hot water heater had been installed.

The facility policy titled, "Water Temperature/Hardness Record" dated November 2006 read, "These checks should be completed and recorded a minimum weekly or more often if needed or required. Recommended check areas would be laundry, kitchen and one resident room per wing."

SUGGESTED METHOD OF CORRECTION:
The DON or designee could educate staff and

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21665	Continued From page 31 conduct periodic audits of areas residents frequent to ensure a safe and home like environment is obtained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the floor tiles in 4 of 4 resident hallways (100, 200, 300 and 400 wings) in a safe and sanitary manner; and failed to replace stained ceiling tiles in 2 of 4 resident hallways (200 and 400 wings). Findings include: During an environmental tour with the administrator and director of environmental services (DES) at 2:00 p.m. on 2/27/14, the following observations were made: There were areas the length of the resident hallways observed to be stained and to have a build up of wax. The floor tiles were observed to be 12 inch square white tiles. Numerous floor tiles throughout the four hallways had become	21695		

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discolored to grayish, charcoal and/or black in color. The discolored areas were noted to be present in long strips throughout the halls.

The 100 wing, 200 wing and 300 wing floors were observed during the environmental tour to have sections of cracked tiles the width of the hallways. At the entrance of the wing, approximately a third of the way down the hallway was another crack that spread across 5 floor tiles. At the entrance of the 400 wing, one section of cracked tiles were observed. The administrator stated during the tour that the cracks could be from the building settling/shifting or just normal wear and tear.

The ceiling tiles down the 200 and 400 wings were observed to have numerous large stained areas present. Some of the tiles appeared discolored a dark tan/gray color and others had a blackish discoloration. The administrator verified during the tour, the ceiling tiles should be changed.

When interviewed on 2/27/14, at 2:30 p.m. the administrator and DES were not sure of the cause for the discolored areas on the floor tiles. The floor care personnel, (FCP)-B was interviewed at that same time and described the process for waxing the floors. FCP-B said the floors were waxed in "strips" so staff could provide care to residents who lived down the halls. FCP-B further stated staff did not routinely strip of the original wax prior to application of a fresh wax. FCP-B said the staff utilized a new product called "GP Forward" which did not remove the old wax very well. The DES verified the old wax build up had not been stripped from the floors.

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21695	Continued From page 33 SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to report timely environmental concerns so they can be addressed timely to provide a safe and sanitary environment for the residents, staff and visitors. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 11 of 52 residents (R10, R13, R26, R31, R32, R36, R39, R45, R53, R65 & R75) who were observed during meal service. Findings include: A dignified dining experience was not provided for 11 residents (R10, R13, R26, R31, R32, R36, R39, R45, R53, R65 & R75) who when interviewed, expressed dissatisfaction with not being served their meals at the same time as their tablemate's. During an interview on 2/25/14, at 11:40 a.m. R10 stated, "I don't like it, they don't serve the entire	21805		

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table, they say it is by how you come to the dining room but how do they know? It was hard to adjust to tablemate's finishing their food before I even got mine. At first I felt awkward but now I'm getting used to it." R10 verified that her dissatisfaction had been expressed to the staff on numerous occasions. According to review of the medical record, R10 had a Brief Interview for Mental Status (BIMS) score on 10/1/13, of 15/15 which indicated cognitively intact.

During subsequent observation/interview on 2/26/14 at 5:44 p.m. R10 was observed seated in the dining room with 3 tablemate's. R10 expressed frustration stating that she had been seated at the table since 5:05 p.m. and still had not yet received her food. Two of the three other residents at R10's table had finished their evening meals while R10 and R31 waited for their food to arrive.

During an interview on 2/25/14, at 5:39 p.m. R13 stated, "I'm not hungry, but the principal is, they get you down here to get the food and you wait with no food while the others at the table eat. The principal should be to all eat at the same time, I don't like this and I feel left out!" During an interview on 2/26/14, at 1:00 p.m. while seated alone eating the noon meal, R13 verified the meals were not enjoyable because of the long wait for meal service and delivery of food. When questioned about the meal, R13 was unable to identify the meat she had been eating and stated, "I don't know what this is, I really don't, it is so dry." R13 verified dissatisfaction with the meals served had been expressed to the staff numerous times. R13 had a BIMS score on 11/27/13, of 15/15 which indicated cognitively intact.

During an interview on 2/25/14, at 11:15 a.m. R26

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stated, "We should be served at the same time, it is uncomfortable to eat when everyone is not served at the same time. It's just good manners." R26 verified that dissatisfaction with the meal service had been expressed to the staff on numerous occasions. R26 had a BIMS score on 1/29/14, of 13/15 which indicated cognitively intact.

During observation/interview on 2/26/14, at 5:44 p.m. R31 was observed seated in the dining room with 3 tablemate's. R31 and R10 had not been served their meals; the 2 other tablemate's were observed finishing their meal. R31 confirmed that she had been waiting since approximately 5:10 p.m. (34 minutes) to be served and that R10 had waited even longer. R31 expressed frustration with the time waiting to be served and also with eating at different times than her tablemate's. R31 confirmed that this occurrence happened often. R31 had a BIMS score on 1/16/14, of 15/15 which indicated cognitively intact.

During an interview on 2/25/14, at 11:20 a.m. R32 expressed dissatisfaction with the long wait for meal service while others who arrived after her were served first. R32 stated, "I'm ok, what can you do, but I don't like watching others get served before me when I was here before them and I don't like watching other people eat when I don't get served with them." Another lady at the table received her meal at 11:15 a.m. and R32 did not receive her meal until 11:40 a.m. (25 minutes later). During an interview on 2/25/14, at 5:39 p.m. after waiting 39 minutes for supper meal service, R32 stated, "This makes me angry because I always have to wait so long. This delay is not good." R32 verified dissatisfaction with the meal service had been expressed to the staff on numerous occasions. R32 had a BIMS score on

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10/1/13, of 9/15 which indicated moderate cognition impairment.

During an interview on 2/25/14, at 5:50 p.m. while a family member (FM) was seated next to F36, the FM stated, "It is not uncommon to have to sit in this room and wait 45 minutes to be served. It is whoever comes first gets served first but it still takes 45 minutes of waiting. It depends on the servers and who the staff are for how long it takes to get service." R36 stated, "Having to wait and watch others eat makes me hungrier by the minute." F36 verified dissatisfaction had been expressed to the staff on numerous occasions. R36 had a BIMS score on 10/1/13, of 99 which indicated the resident was unable to complete the interview.

During an interview on 2/25/14, at 11:35 a.m. R39 stated, "If you come in late you get served last. If you come first you get served first. I don't like it but I am used to it now." R39 was sitting at a table with 5 other ladies. R39 verified dissatisfaction with the meal service had been expressed to the staff on numerous occasions. R39 had a BIMS score on 10/1/13, of 14/15 which indicated cognitively intact.

During observation/interview on 2/26/14 at 5:45 p.m. R45 was observed seated in the dining room with 3 tablemate's. Two of the three residents seated at the table had received their meals at 5:30 p.m. and R45's tray arrived at 5:45 p.m. R53 remain seated at the table while the other three residents consumed their food. R45 indicated that no ever receives their meals at the same time so they can eat together. R45 stated you arrive at 5:00 p.m. and sit and wait. R45 stated, 'Sometimes it is a half an hour, sometimes it is an hour!' R45 had a BIMS score on 12/4/13 of 15/15

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which indicated cognitively intact.

During observation/interview on 2/26/14, at 5:45 p.m. R53 summoned the surveyor to the table. R53 indicated her frustration with the meal service as she had been in the dining room since 5:00 p.m. R53 stated "it is like this all the time; You come at 5 and you wait. It can be 30 minutes, 45 minutes or an hour! We never get our food at the same time." R53 stated that two tables received their meals at 5:30 p.m., R45 received his meal at 5:40 p.m. It was observed that R53 was served at 5:50 p.m. R53 had a BIMS score on 12/25/13 of 15/15 which indicated cognitively intact.

During an interview on 2/25/14, at 11:43 a.m. R65 stated, "It doesn't matter when you come here, you wait." R65 further verified she dislikes the long "wait" times for meal service and thinks that may be a reason for the overcooked vegetables and meats routinely. R65 verified dissatisfaction with the meal service had been expressed to the staff on numerous occasions. R 65 had a BIMS score on 10/1/13, of 15/15 which indicated cognitively intact.

During an interview on 2/25/14, at 11:23 a.m. R 75 stated "It would be nice if we were all eating together". Another resident at the same table received the meal at 11:15 a.m. and 25 minutes later, R 75 received her meal at 11:40 a.m. During an interview on 2/25/14, at 5:45 p.m. R 75 verified she came to the dining room at 5:00 p.m. and it was not unusual to wait forty five minutes or longer to be served the evening meal. R 75 verified dissatisfaction had been expressed to the staff on numerous occasions. R 75 had a BIMS score on 10/1/13, of 15/15 which indicated cognitively intact.

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During several observations in the dining room during meal service, dietary aides referred to R13 "Hon". It was noted on 2/26/14, at 1:00 p.m. that R13 was asked whether she needed anything else while in the dining room and the dietary aide referred to her as "Hon" several times. R13 stated to the surveyor, "Do you hear that? Why do they bother to put my name right here on the table for everyone to see and then still call me pet names when my name is [R13]!" R13 confirmed this occurs frequently and does not want a single person identified as using the terms: Hon, Honey or Darling but prefers staff to address her by name.

A review of the facility policy dated 8/12, titled, "Open Dining" read, Residents do not wait more than 10-15 minutes to be served. Batch cooking is required to ensure high-quality food with nutrient retention. Food should be kept no longer than 30 minutes on the steam table.

During interview on 2/27/14, at 9:49 a.m. the dietary manager verified that residents are to be served as they come into the dining room.

During interview on 2/27/14, at 1:11 p.m. the dietary manager (DM) confirmed the wait time during the supper meal on 2/26/14 for some of the residents was up to an hour. The DM indicated this was unusual stating, " We've watched tapes too and we've never found anywhere that the wait time was over a half hour." The DM stated that during the evening meal a half hour wait time for meal service is acceptable because all residents tend to be present in the dining room at 5:00 p.m., "and everybody can't be first". The DM confirmed that only two dietary staff are routinely responsible for serving food to

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21805	Continued From page 39 all of the residents and that no other staff are utilized to assist with food service during meal times. SUGGESTED METHOD OF CORRECTION: The director of nursing or social services could in-service all staff on the need to treat all residents with respect and dignity. The Quality Assessment and Assurance committee could develop a system to audit employees for dignified care and services toward residents in the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to act upon resident grievances related to quality of food and timeliness of food service. This had the potential to affect all residents who received their meals from the facility's kitchen. Findings include: During interview on 2/26/14, at 2:30 p.m. R33 stated, "The food isn't very good here". R33 further stated the timeliness of food service, the quality of the food and the temperature of the	21870		

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food being too cold was an issue as well. R33 indicated that about a month ago the residents were served meatballs that tasted like they had been "taken off of some leftover spaghetti; there were people who usually don't complain about the food that were complaining about that". She further stated, "They just plop it on the plate". R33 confirmed the food did not look appetizing and stated although she doesn't care for meat, a sprig of green on the plate would improve the appearance. R33 stated these concerns had been brought up several times at resident council meetings with no improvement.

During interview on 2/24/14, at 12:50 p.m. R53 expressed dissatisfaction with the food served stating, "Today at lunch the noodles were cold, the chicken breast was dry with no gravy and the green bean casserole was not good. They will give you your yogurt on a hot plate and your omelet on a cold plate! The food is usually not the right temperature. They keep saying they are working on it but it doesn't change".

The resident council meeting minutes were reviewed and documentation included:
(1) 9/11/13- brought up the concern of how the coffee cups are cleaned as they have been dirty when coffee is served to residents; people have left her table after waiting over an hour for their food; Other residents agreed and questioned the serving priority between the Village and the Lodge; [resident] also brought up that food has been inadequately prepared; ribs have been burnt and potatoes have been burnt and/or served raw. According to the notes, staff in attendance at the resident council meeting had indicated the issues would be communicated with the dietary manager (DM);
(2) 8/14/13- several residents questioned the

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serving priority of who gets served when for mealtimes; the dietary manager verified that mealtimes should be served on a "first come, first served" approach but residents said that is not how it happens. The dietary manager indicated she would talk with dietary staff at their next meeting and also reminded residents that the waiting time would not include time spent waiting before the official start of mealtimes and that she could check waiting times on videotape and talk to her staff;
(3) 7/10/13-resident mentioned that the ice cream bar is usually melted by the time he receives it and the resident were reminded to ask dietary staff to place in freezer until the residents are ready for their frozen desserts; and
(4) 6/12/13-several residents stated they have had to wait a long time for some meals to be served; and dietary manager will look into it.

Documentation was lacking to indicate the concerns and recommendations expressed during the resident council meetings had been acted upon and discussed with residents to assure the grievances had been remedied.

During interview on 2/27/14, at 12:58 p.m. with the licensed social worker (LSW) it was confirmed that residents concerns expressed at resident council meetings are not documented on a grievance form. The LSW stated that resident complaints related to dining are communicated to the dietary manager to address and follow-up. The LSW further stated, "The timeliness of the food service has been a long term issue and we're kind of at a loss". The LSW confirmed that staff do not routinely follow-up with concerns/complaints from the previous resident council meeting unless the residents bring the issues up again. She confirmed they had no

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21870	Continued From page 42 system to follow up with the concerns expressed from one meeting to the next. The LSW stated the resident council meeting notes are reviewed at the Quality Assurance (QA) quarterly meetings and that in the past the QA committee had implemented a resident food committee and that dining complaints had subsequently "dwindled", hence, the committee was eventually discontinued. The LSW further stated the food committee had met from 8/8/11 until 4/19/12, and it could be reinstated and "revamped" if necessary. During an interview with the DM on 2/27/14, at 1:11 p.m., the DM stated the staff who had been cooking during the period from June 2013 until September 2013, had trouble serving meals in a timely manner. However the DM confirmed the cook in question was no longer employed as a cook at the facility. The DM confirmed the food service during the current week had been slow and was very unusual stating, "This hasn't happened in months". She further confirmed the wait time for the supper meal on 2/26/14, was up to an hour for some of the residents. The DM stated she thought an acceptable wait time for the supper meal would be a half hour because all residents tend to be present in the dining room at 5:00 p.m., "and everybody can't be first". The DM confirmed there were always 2 dietary staff responsible for serving the food to the residents at mealtimes and staff from other disciplines are not utilized to help with the food service. The DM also acknowledged that the tuna melts served for supper on 2/26/14, had been overcooked and the cook "should have started over". The facility form titled, Guidelines Meal Service/Dining Open Dining, revised 8/12 included: "Open dining includes the following:	21870		

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21870	Continued From page 43 Residents do not wait more than 10 to 15 minutes to be served". The facility procedure titled, Grievances, "Complaints or Concerns, revised January 2007 included: 2. When a resident, family member, visitor or staff member expresses a concern or grievance to a staff member related to resident care or services, it will be received in an open, friendly, non-judgmental manner and without discrimination or reprisal. 3. If the problem can be resolved immediately, the staff member will thank the individual for the information and proceed to take action regarding that problem. The grievance will then be documented on the Suggestion or Concern (GSS #213) and submitted to the center social services director. 4. If the complaint comes directly to the social services department, then the director of social services will complete a Suggestion or Concern (GSS #213) form upon receipt of the complaint. 5. The social services director will route the Suggestion or Concern (GSS #213) to the appropriate department head as soon as is reasonably possible... 6. An investigation must be completed for all grievances. The investigation may be informal, but must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint... 7. The social services director will then report the findings to the individuals filing the concern and to the center administrator... 8. If the grievance is not resolved, the center social services director will channel the concern directly to the administrator. On weekends and holidays, all concerns that pose an immediate danger will be handled by the weekend	21870		

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21870	Continued From page 44 supervisor. The weekend supervisor will then take the necessary action to start an investigation and notify the necessary personnel. It is recommended that non-threatening concerns will be forwarded to the social worker and resolved within two working days ; and 9. The social services director will maintain a confidential file of documented concerns and report trends and actions to the quality committee..." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could provide staff education relating to policy and procedure for resident greivance and resolution. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21870		