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 245549	(Y2) Multiple Cons A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 6/12/2014
Name of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - MOUN	ITAIN LAKE	745 BASINGER MEMORIAL DR MOUNTAIN LAKE, MN 56159	IVE

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

(Y4) Item		(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix		C	Correction Completed 5/13/2014	ID Prefix		Correction Completed		ID Prefix			Correction Completed
	NFPA 101			Reg. #				Reg. #			
LSC	K0025			LSC				LSC _			
		C	Correction			Correction					Correction
			Completed			Completed					Completed
ID Prefix											
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Reg. #				Reg. #				Reg. #			
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		C	Correction			Correction					Correction
		C	Completed	ID Profix		Completed		ID Profix			Completed
Reg. #				Reg. #							
								LSC			
			Correction			Correction					Correction
ID Prefix		C	Completed	ID Prefix		Completed		ID Prefix			Completed
				Reg. #				– "			
LSC								LSC _			
Reviewed I	By Review	ved E	Зу	Date:	Signature of Surv	veyor:				Date:	
State Agen	су										
Reviewed I	By Review	ved E	Зу	Date:	Signature of Surv	veyor:				Date:	
CMS RO											
Followup t	o Survey Completed	l on:			Check for any Uncor						
	4/22/2014				Uncorrected Defic	iencies (CM	13-256	or) Sent to t	ne 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 <u>all</u> 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.

Page 2

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 <u>written</u> request for a hearing must be filed <u>no later than 60 days</u> 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

Page 5

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 O	OF HEALTH A					CENTERS FOR MEI	DICARE & MEDIC	CAID SERVICES		
						AND TRANSMITTAL		ID: EVOZ		
		PART I -	TO BE COMPL	LETED BY	THE STA	TE SURVEY AGENCY		Facility ID: 00755		
1. MEDICARE/MEDICA	AID PROVIDER	NO.	3. NAME AND AL			IOUNTAIN LAKE	4. TYPE OF ACTIC	DN: <u>7 (</u> L8)		
(L1) 245549 2.STATE VENDOR OR 1			(L4) 745 BASINO				1. Initial	2. Recertification		
(L2) 477840500	WEDICAID NO.		(L5) MOUNTAIN			(L6) 56159	3. Termination 5. Validation	4. CHOW 6. Complaint		
5. EFFECTIVE DATE C (L9)	CHANGE OF OW	/NERSHIP	7. PROVIDER/SU	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other r Complaint		
6. DATE OF SURVEY	04/21/20	014 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESKD 10 NF	14 CORF				
8. ACCREDITATION S		(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		FISCAL YEAR ENDI	NG DATE: (L35)		
0 Unaccredited	1 TJC	(210)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30			
2 AOA	3 Other									
11LTC PERIOD OF CE	ERTIFICATION		10.THE FACILITY		AS:					
From (a):			X A. In Complia			And/Or Approved Waivers Of				
To (b):				equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Se 7. Medical Dir			
12.Total Facility Beds		55 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN				
						5. Life Safety Code	9. Beds/Room			
13.Total Certified Beds		55 (L17)	B. Not in Cor Requirem	npliance with Pro- ents and/or Appli	gram ied Waivers:	* Code: A	(L12)			
14. LTC CERTIFIED BE	D BREAKDOW	N				15. FACILITY MEETS				
18 SNF	18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37)	55 (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AG	GENCY REMAR	KS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):					
Post certification	n revisit (PC	R) of Health	and Life Safet	y Code Surv	veys com	pleted on April 21, 2014.	. Refer to CMS for	m 2567B.		
		*		•	•					
17. SURVEYOR SIGNA	ATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:		
Kathryn Serie, Ur	nit Superviso	or	(05/01/2014	(L19)	Kamala Fiske-Downing, Enforcement Specialist 06/19/2014 (L20)				
	PART	TII - TO BE	COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY			
19. DETERMINATION	OF ELIGIBILIT	Y		IPLIANCE WIT	H CIVIL	21. 1. Statement of Fina				
X 1. Facility	is Eligible to Parti	icipate	RIGI	HTS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt e :	(HCFA-1513)		
2. Facility	is not Eligible									
		(L21)								
22. ORIGINAL DATE	2	23. LTC AGREEN	MENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)		
OF PARTICIPATIO	N	BEGINNING	J DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLUN</u>	NTARY		
02/01/1991						01-Merger, Closure	05-Fail to	Meet Health/Safety		
(L24)		(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement		
25. LTC EXTENSION	DATE: 2	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER			
		A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-110010	er Status Change		
	(L27)	D. Dessind St	spension Date:	(L44)			00-Active			
		D. Reselliu St	ispension Date.	(L45)						
28. TERMINATION DA	ATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS				
			00140							
		(L28)			(L31)					
31. RO RECEIPT OF CM	MS-1539	32	. DETERMINATION	N OF APPROVAL	DATE					
			04/22/2014							

(L33)

DETERMINATION APPROVAL

(L32)



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,

Kumalu 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 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,

Kumalu 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 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 245549	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/21/2014
Name	e of Facility		Street Address, City, State, Zip Code	
G	DOD SAMARITAN SOCIETY - MOUN	TAIN LAKE	745 BASINGER MEMORIAL DR MOUNTAIN LAKE, MN 56159	IVE

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
	F0241 483.15(a)		Correction Completed 03/20/2014		F0244 483.15(c)(6)		Correction Completed 03/20/2014			F0253 483.15(h)(2)		Correction Completed 03/20/2014
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 03/20/2014	ID Prefix Reg. # LSC	F0312 483.25(a)(3)		Correction Completed 03/20/2014			F0323 483.25(h)		Correction Completed 03/20/2014
ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 03/20/2014	ID Prefix Reg. # LSC	F0364 483.35(d)(1)-(2)		Correction Completed 03/20/2014		ID Prefix Reg. # LSC	F0371 483.35(i)		Correction Completed 03/20/2014
ID Prefix Reg. # LSC	483.60(c)		Correction Completed 03/20/2014	ID Prefix Reg. # LSC	483.70(h)		Correction Completed 03/20/2014		Reg. #			
ID Prefix Reg. # LSC			Correction Completed	Reg. #					Б "			
Reviewed I	By R	eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
State Agen	су	KS/KFI)	05/08/20	14		0304	18				04/21/2014
		eviewed		Date:	Signature	of Sur	veyor:				Date:	
Followup t	to Survey Comp 2/27/20		:		Check for any Uncorrecte					Summary of the Facility?	YES	NO

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 245549	(Y2) Multiple Const A. Building B. Wing	Ving 02 - 2013 LINK ADDITION		(Y3) Date of Revisit 4/7/2014
Name of Facility			Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - MOUN	ITAIN LAKE		745 BASINGER MEMORIAL DR MOUNTAIN LAKE, MN 56159	IVE

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 03/03/2014	ID Prefix		Correction Completed	ID Prefix		Correction Completed
0	NFPA 101		Reg. #			Reg. #		
LSC	K0052		LSC			LSC		
		Correction			Correction			Correction
ID Drofiv		Completed	ID Brofiv		Completed	ID Drofiv		Completed
ID Prefix								
Reg. # LSC			Reg. #			Reg. # LSC		
		Correction			Correction			Correction
ID Desfer		Completed			Completed	ID Draffin		Completed
ID Prefix								
Reg. # LSC			Reg. #			Reg. # LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #								
LSC			LSC			LSC		
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #			Reg. #			Reg. #		
LSC			LSC			LSC		
Reviewed E	By Rev	iewed By	Date:	Signature of Sur	veyor:		Dat	e:
State Agen	cy (S/KFD	05/08/2014		2232	73		04/07/2014
Reviewed E CMS RO	3y — Rev	iewed By	Date:	Signature of Sur	veyor:		Dat	e:
Followup t	o Survey Complet 2/25/201			Check for any Uncor Uncorrected Defic				S NO

DEPARTMENT OF HEALTH AND HUMA	N SERVICES CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				
	ARE/MEDICAID CERTIFICATION AND TRANSM TO BE COMPLETED BY THE STATE SURVEY A					
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245549	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - MOUNTAIN LA	4. TYPE OF ACTION: <u>2 (</u> L8)				

(L1) 245549 2.STATE VENDOR OR (L2) 477840500 5. EFFECTIVE DATE C (L9)		RSHIP	 (L2) GOOD SAM (L4) 745 BASING (L5) MOUNTAIN 7. PROVIDER/SU 01 Hospital 	ER MEMOR LAKE, MN	IAL DRIV	E	56159	 Initial Termination Validation On-Site Visit Full Survey After 	 Recertification CHOW Complaint Other Complaint
 DATE OF SURVEY ACCREDITATION S⁶ 0 Unaccredited 2 AOA 	02/27/2014 TATUS: 1 TJC 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IIE 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN 09/30	NG DATE: (L35)
11LTC PERIOD OF CE	RTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):			A. In Complian	nce With		And/Or Appro	oved Waivers Of	The Following Requireme	ents:
To (b):			0	equirements e Based On:		2. Tech 3. 24 F	nical Personnel Iour RN	6. Scope of Ser 7. Medical Dire	
12.Total Facility Beds	5	55 (L18)	1. Ao	cceptable POC			ay RN (Rural SN Safety Code	IF)8. Patient Roon 9. Beds/Room	n Size
13.Total Certified Beds	5	55 (L17)		pliance with Pro ents and/or Appli			В	(L12)	
14. LTC CERTIFIED BE	D BREAKDOWN					15. FACILITY M	IEETS		
18 SNF	18/19 SNF 55	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37)	(L38)	(L39)	(L42)	(L43)					

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 :	18. STATE SURVEY AGENCY APPROVAL	Date:							
Pamela Manzke, HFE NE II 03/31/2014 Kamala Fiske-Downing, Enforcement Specialist 04/21/2014 DAPET H. TO BE COMPLETED BY LICEA DECIONAL OFFICE OF SINCLE STATE ACENCY										
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY										
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572								
1. Facility is Eligible to Participate	RIGHTS ACT:	 Ownership/Control Interest Disclosure Stmt (Both of the Above : 	HCFA-1513)							

2. Facility is not Eligibl	le (L21)			_
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 02/01/1991	BEGINNING DATE	ENDING DATE	VOLUNTARY 00 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions:	S	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
(L27)	B. Rescind Suspension Date:	(L44)		00-Active
		(L45)		
28. TERMINATION DATE:	29. INTERMEDIA	ARY/CARRIER NO.	30. REMARKS	
	00140			
	(L28)	(L31)	_	
31. RO RECEIPT OF CMS-1539	32. DETERMINAT	ΓΙΟΝ OF APPROVAL DATE		
	(L32)	(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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. 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,

Kumala 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

Enclosure

cc: Licensing and Certification File

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUI		E CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		CO	MPLETED
		245549	B. WING			02	/27/2014
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			5 BASINGER MEMORIAL DRIVE OUNTAIN LAKE, MN 56159		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC		(75)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 000	The facility's plan c as your allegation o Department's accep	S f correction (POC) will serve f compliance upon the otance. Your signature at the age of the CMS-2567 form will	F (000	Preparation and execution of response and plan of correct does not constitute an admi- agreement by the provider of truth of the facts alleged or	tion ssion or	
F 241 SS=E	be used as verifcati Upon receipt of an revisit of your facilit validate that substa regulations has bee your verification. 483.15(a) DIGNITY INDIVIDUALITY The facility must pro- manner and in an e enhances each resi	on of compliance. acceptable POC an on-site y may be conducted to ntial compliance with the in attained in accordance with AND RESPECT OF		241	conclusions set forth in the statement of deficiencies. T of correction is prepared and executed solely because it is required by the provisions o and state law. For the purpe any allegation that the center in substantial compliance wi federal requirements of part this response and plan of co constitutes the center's alleg compliance in accordance w section 7305 of the State Op	d/or s f federal ose of r is not th cipation, rrection jation of ith	
	by: Based on observat review, the facility fa dining experience fo R13, R26, R31, R32	AT is not met as evidenced ion, interview and document ailed to provide a dignified or 11 of 52 residents (R10, 2, R36, R39, R45, R53, R65 & erved during meal service.	2/2	rese 8 7 1	section 7305 of the State Or _ Manual.		
	11 residents (R10, F R39, R45, R53, R65 interviewed, express	perience was not provided for R13, R26, R31, R32, R36, 5 & R75) who when sed dissatisfaction with not heals at the same time as			RECEIVE MAR 2 7 2 Manestoa Department or Marchall	014	
ORATORY	DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE
= 1	1 San C				AJ istrator	-	

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245549	B. WING			02/2	27/2014
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE		74	TREET ADDRESS, CITY, STATE, ZIP CODE 45 BASINGER MEMORIAL DRIVE IOUNTAIN LAKE, MN 56159		Ĩ
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	During an interview stated, "I don't like table, they say it is room but how do th to tablemate's finis got mine. At first I f getting used to it." dissatisfaction had numerous occasion medical record, R1 Mental Status (BIW which indicated cost During subsequent 2/26/14 at 5:44 p.m the dining room wit expressed frustrati seated at the table not yet received he residents at R10's meals while R10 at arrive. During an interview stated, "I'm not hur get you down here with no food while principal should be don't like this and I interview on 2/26/1 alone eating the no meals were not enj wait for meal servic questioned about t identify the meat sl "I don't know what dry." R13 verified d	y on 2/25/14, at 11:40 a.m. R10 it, they don't serve the entire by how you come to the dining ney know? It was hard to adjust hing their food before I even elt awkward but now I'm R10 verified that her been expressed to the staff on ns. According to review of the 0 had a Brief Interview for IS) score on 10/1/13, of 15/15 gnitively intact. tobservation/interview on n. R10 was observed seated in th 3 tablemate's. R10 on stating that she had been since 5:05 p.m. and still had r food. Two of the three other table had finished their evening nd R31 waited for their food to y on 2/25/14, at 5:39 p.m. R13 ngry, but the principal is, they to get the food and you wait the others at the table eat. The to all eat at the same time, I feel left out!" During an 4, at 1:00 p.m. while seated bon meal, R13 verified the ioyable because of the long ce and delivery of food. When he meal, R13 was unable to ne had been eating and stated, this is, I really don't, it is so lissatisfaction with the meals xpressed to the staff numerous BIMS score on 11/27/13, of		241	F241 DIGNITY AND RESPEC INDIVIDUALITY Resident #13 has been consult and has established that she d not appreciate being called "Ho Staff were informed during inservices held on 3/4/14, 3/6/1 3/13/14; 3/17/14, 3/19/14 & 3/2 on the rights and dignity of all residents and that we need to address them in a fashion whic they prefer and find respectful. Inquiries of residents about how are addressed by staff is done time of admission and will cont to be recorded if they have a preferred name. The Social W or her designee will survey sev residents each week times one month and then once a month 3 months to determine if they fe they are addressed in an appro fashion. All findings will be presented at the regular month Quality Assurance meetings ar further action, if needed will be determined by the interdisciplin team.	ed oes on". 14, 20/14 th w they at the inue orker eral times eel opriate ly ad any hary	L Page 2 of 42

RECEIVED MAR 2 7 2014

Manestoa Department of Health Marshall

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		AND HUMAN SERVICES & MEDICAID SERVICES		,		FORM	03/14/201 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245549	B. WING	G		02/	27/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			45 BASINGER MEMORIAL DRIVE NOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIO DATE
F 241		ge 2 ed cognitively intact.	F	241	Concerns with the dining expo have been and continue to be evaluated. Current policy is t)	
	stated, "We should is uncomfortable to served at the same	on 2/25/14, at 11:15 a.m. R26 be served at the same time, it eat when everyone is not time. It's just good manners."			provide "Open Meals" which s we will serve residents in the in which they enter the dining	states order room	
	service had been e numerous occasior	ssatisfaction with the meal xpressed to the staff on ns. R26 had a BIMS score on hich indicated cognitively			and residents will not wait mo 10 – 15 minutes for their mea Dietary staff were educated o 3/4/14 & 3/19/14, and Nursing were educated on 3/6/14, 3/1	l. n g staff 3/14 & .	
	p.m. R31 was obse with 3 tablemates. served their meals;	interview on 2/26/14, at 5:44 rved seated in the dining room R31 and R10 had not been the 2 other tablemate's were their meal. R31 confirmed that			3/20/14 on the need to provid timely service in the dining roo manner acceptable to each re and serve food that is palatab enjoyed by residents. A Food	om in a esident le and	
	she had been waiti p.m. (34 minutes) t waited even longer with the time waitin	ng since approximately 5:10 be served and that R10 had R31 expressed frustration g to be served and also with mes than her tablemate's.			Committee has been establish with representation from Resid Nursing, Dietary, Activities, ar Social Service. This committee met on 2 occasions, on 3/17/1	dents, nd ee has	
	R31 confirmed that often. R31 had a E 15/15 which indicat	this occurrence happened IMS score on 1/16/14, of ed cognitively intact.			3/20/14 and will continue to m least monthly to explore all iss associated with the dining experience, including how me	eet at sues	
	expressed dissatisf meal service while were served first. R	on 2/25/14, at 11:20 a.m. R32 action with the long wait for others who arrived after her 32 stated, "I'm ok, what can ke watching others get served			scheduled, menu choices and foods are served and present Each resident that is able to b interviewed will be polled to	ways ed.	
	before me when I w don't like watching get served with the received her meal a	vas here before them and I other people eat when I don't m." Another lady at the table at 11:15 a.m. and R32 did not	*		determine their preferences a allow them input into any char that might be made.		
	later). During an in p.m. after waiting 3	ntil 11:40 a.m. (25 minutes terview on 2/25/14, at 5:39 9 minutes for supper meal , "This makes me angry					

If continuation sheet Page 3 of 42 RECEIVED

MAR 2 7 2014 Manestoa Department of Health Marshall

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LTIPL	LE CONSTRUCTION		E SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING		COM	IPLETED
		245549	B. WING	·		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	' - MOUNTAIN LAKE			45 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO)N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETIO
F 241	Continued From pa	age 3	F	241			
		nave to wait so long. This delay			Periodic audits to determine se		!
		erified dissatisfaction with the			times of various meals will be o		
		been expressed to the staff on			at least 2 X weekly by the dieta		
		ns. R32 had a BIMS score on hich indicated moderate			manager or her designee for th		
	cognition impairme				month and then weekly x 3 mo and then periodically as neede		
	U I				as schedules are adjusted. Me		
		v on 2/25/14, at 5:50 p.m. while			quality will be audited by the D		
		FM) was seated next to F36,			Manager or her designee for a		
		s not uncommon to have to sit ait 45 minutes to be served. It			3 meals per week for the first r		
1999 (M. 1997)		first gets served first but it still			and then at least one meal per		
	takes 45 minutes of	of waiting. It depends on the			for the next 2 months. All audi		
		ne staff are for how long it takes			results will be reported at the F	ood	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1
		6 stated, "Having to wait and nakes me hungrier by the			Committee Meeting and at the		
in the second		ed dissatisfaction had been			monthly QA meetings and furth action, if necessary will be	her	
	expressed to the s	taff on numerous occasions.			determined by the interdisciplir	arv	1
4 b.e.		core on 10/1/13, of 99 which			committee. Completion Date	iai y	31
	indicated the reside	ent was unable to complete the			3/20/2014		120
	interview.						
	During an interview	v on 2/25/14, at 11:35 a.m. R39					-
		e in late you get served last. If					
		get served first. I don't like it	-				
	table with 5 other la	now." R39 was sitting at a					
		the meal service had been					
	expressed to the s	taff on numerous occasions.					
		core on 10/1/13, of 14/15 which			· ·		
	indicated cognitive	iy intact.					
	During observation	/interview on 2/26/14 at 5:45					
	0	erved seated in the dining room					
	with 3 tablemates.	Two of the three residents					· · ·
		had received their meals at			4		
		's tray arrived at 5:45 p.m. R53 ne table while the other three					1.1
		ed their food. R45 indicated			3		p

MAR 2 7 2014

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

					<u> </u>		0930-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY
		245549	B. WINC	3		02	/27/2014
	PROVIDER OR SUPPLIER			74	TREET ADDRESS, CITY, STATE, ZIP CODE 45 BASINGER MEMORIAL DRIVE IOUNTAIN LAKE, MN 56159	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
A	time so they can ea arrive at 5:00 p.m. a 'Sometimes it is a h hour!' R45 had a Bl which indicated cog During observation, p.m. R53 summone R53 indicated her fi service as she had 5:00 p.m. R53 state You come at 5 and minutes, 45 minute our food at the sam tables received their received his meal a that R53 was serve BIMS score on 12/2	es their meals at the same at together. R45 stated you and sit and wait. R45 stated, half an hour, sometimes it is an IMS score on 12/4/13 of 15/15	F.	241			
	stated, "It doesn't m you wait." R65 furth long "wait" times for may be a reason fo and meats routinely with the meal service staff on numerous of score on 10/1/13, of cognitively intact. During an interview stated "It would be n together". Another received the meal at later, R75 received During an interview	y on 2/25/14, at 11:43 a.m. R65 natter when you come here, her verified she dislikes the r meal service and thinks that or the overcooked vegetables y. R65 verified dissatisfaction ce had been expressed to the occasions. R 65 had a BIMS of 15/15 which indicated y on 2/25/14, at 11:23 a.m. R75 nice if we were all eating resident at the same table at 11:15 a.m. and 25 minutes her meal at 11:40 a.m. y on 2/25/14, at 5:45 p.m. R75 o the dining room at 5:00 p.m.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: EVOZ11

Facility ID: 00755

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Manestoa Department of Health Marshall PRINTED: 03/14/2014 FORM APPROVED OMB NO 0938-0391

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATI	E SURVEY PLETED
		245549	B. WING			02/	27/2014
NAME OF	PROVIDER OR SUPPLIER		·]	STREET ADDRESS, CIT	Y, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEM MOUNTAIN LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	'S PLAN OF CORRECTIO ECTIVE ACTION SHOULI ENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 241	longer to be served verified dissatisfact staff on numerous o	ge 5 ual to wait forty five minutes or the evening meal. R75 ion had been expressed to the occasions. R75 had a BIMS f 15/15 which indicated	F 2	:41			
	during meal service "Hon". It was noted R13 was asked who else while in the din referred to her as "H stated to the survey do they bother to put table for everyone t names when my na this occurs frequent person identified as	ervations in the dining room e, dietary aides referred to R13 on 2/26/14, at 1:00 p.m. that ether she needed anything ing room and the dietary aide Hon" several times. R13 for, "Do you hear that? Why at my name right here on the o see and then still call me pet me is [R13]!" R13 confirmed thy and does not want a single using the terms: Hon, Honey rs staff to address her by					
	"Open Dining" read than 10-15 minutes is required to ensur	ity policy dated 8/12, titled, , Residents do not wait more to be served. Batch cooking e high-quality food with ood should be kept no longer the steam table.				-	ی کی این این این این این این این این این این این این
	dietary manager ver served as they com During interview on dietary manager (Di during the supper m the residents was u indicated this was u	2/27/14, at 9:49 a.m. the rified that residents are to be e into the dining room. 2/27/14, at 1:11 p.m. the M) confirmed the wait time heal on 2/26/14 for some of p to an hour. The DM nusual stating, "We've and we've never found					
FORM CMS-25	67(02-99) Previous Versions	; 	 I	Facility ID: 00755	If continua	ation sheet	Page 6 of 42

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

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

CENTE	RS FOR MEDICARE	<u>& MEDICAID SERVICES</u>			O	MB NO.	. 0938-0391
1	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245549	'B. WING	G		02/	27/2014
NAME OF I	PROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • •	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • • • • • • • • • • • •	
				7	45 BASINGER MEMORIAL DRIVE		
GOODS	AMARITAN SOCIETY	- MOUNTAIN LAKE		N	IOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
5044							مىلىيىت. ئۇلمۇس ب
F 241	Continued From pa	-	F2	241			
	anywhere that the v	vait time was over a half hour."					
		during the evening meal a					12.1
		for meal service is acceptable					
		ts tend to be present in the					
	be first" The DM o	p.m., "and everybody can't onfirmed that only two dietary					
		esponsible for serving food to					• • •
. 197		and that no other staff are					
		h food service during meal					111
	times.						
F 244	483.15(c)(6) LISTE	N/ACT ON GROUP	F 2	244	F244 FAILURE TO LISTEN TO		1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1
SS=E	GRIEVANCE/RECO	OMMENDATION			ACT ON GROUP GRIEVANCE	UR	
					RECOMMENDATIONS		
شيد، د د د		family group exists, the facility			Issues addressed at the month	•	
ing Colo		ews and act upon the	•		Resident Council Meeting and a		
		ommendations of residents			other concerns voiced by reside		
		ning proposed policy and			and/or families will be logged an		
	life in the facility.	ns affecting resident care and			addressed by appropriate staff		
	me in the facility.				timely manner. Each concern w	vill be	())
					recorded on the GSS#213		
	This REQUIREMEN	NT is not met as evidenced			Suggestion or Concern form an	d will	
	by:				be directed to the appropriate	<u>.</u>	
	Based on observat	ion, interview and document		1	department head to investigate		
		ailed to act upon resident			address. Completed forms will		
		to quality of food and			reviewed and filed and will be k	ept in	
		ervice. This had the potential			a confidential file by the Social		(
-		s who received their meals			Worker. The Social Worker or h	er	
	from the facility's kit	cnen.			designee will audit all forms for		
8-0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0	Findings include:				completeness and evidence of		
	r mango melade.				follow-up. The Social Worker w		
	During interview on	2/26/14, at 2:30 p.m. R33			report trends and actions at the		
	stated, "The food is				monthly Quality Assurance mee		· · .
		he timeliness of food service,			and any further action, if neede	d will	
		od and the temperature of the			be determined by the		
	food being too cold	was an issue as well. R33		-	interdisciplinary team.		-2/
•	indicated that about	a month ago the residents		1	Completion Date 3/20/2014		3/20/14
							10-114

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: EVOZ11

Facility ID: 00755

If continuation sheet Page 7 of 42

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MAR 27 2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/14/2014 APPROVED 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION		TE SURVEY MPLETED
	•	245549	B. WING	÷		02	/27/2014
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP COD		t s st s s
GOOD SA	MARITAN SOCIETY	- MOUNTAIN LAKE			45 BASINGER MEMORIAL DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5). COMPLETION DATE
	been "taken off of s were people who us food that were com	balls that tasted like they had some leftover spaghetti; there sually don't complain about the plaining about that". She		244			
	R33 confirmed the and stated although sprig of green on th appearance. R33 s	y just plop it on the plate". food did not look appetizing n she doesn't care for meat, a ne plate would improve the stated these concerns had everal times at resident counci nprovement.					1.17 - 92014 HPF (17E1) 11945-0364 Norther Norther
	expressed dissatisf stating, "Today at lu the chicken breast green bean casserc give you your yogur omelet on a cold pla	2/24/14, at 12:50 p.m. R53 faction with the food served unch the noodles were cold, was dry with no gravy and the ole was not good. They will t on a hot plate and your ate! The food is usually not the They keep saying they are doesn't change".					
	reviewed and docur (1) 9/11/13- brough coffee cups are clea when coffee is serv left her table after w food; Other resider serving priority betw Lodge; [resident] als been inadequately p and potatoes have l According to the no resident council me would be communic (DM); (2) 8/14/13- severa	il meeting minutes were mentation included: nt up the concern of how the aned as they have been dirty red to residents; people have vaiting over an hour for their nts agreed and questioned the veen the Village and the so brought up that food has prepared; ribs have been burn been burnt and/or served raw. tes, staff in attendance at the reting had indicated the issues cated with the dietary manager al residents questioned the ho gets served when for					
LL-	7(02-99) Previous Versions		11	Fa	cility ID: 00755 If co	ntinuation she	et Page 8 of 42

		AND HUMAN SERVICES			antona Antonio de Carlos de Carlos Antonio		NTED: 03/14/2014 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		X3) DATE SURVEY COMPLETED
-		245549	B. WING	G			02/27/2014
NAME OF F	PROVIDER OR SUPPLIER	L			EET ADDRESS, CITY, STATE,		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			BASINGER MEMORIAL DF UNTAIN LAKE, MN 561		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD B THE APPROPRI	
F 244	mealtimes; the diet mealtimes should b served" approach b how it happens. Th she would talk with meeting and also re waiting time would before the official s could check waiting to her staff; (3) 7/10/13-resider cream bar is usuall receives it and the dietary staff to plac are ready for their f (4) 6/12/13-severa had to wait a long t served; and dietary Documentation was concerns and recound during the resident acted upon and dis assure the grievant During interview on the licensed social confirmed that resider a grievance form. T complaints related the dietary manage The LSW further st food service has be	ary manager verified that be served on a "first come, first out residents said that is not ne dietary manager indicated dietary staff at their next eminded residents that the not include time spent waiting tart of mealtimes and that she g times on videotape and talk in mentioned that the ice by melted by the time he resident were reminded to asl e in freezer until the residents frozen desserts; and it residents stated they have ime for some meals to be manager will look into it. s lacking to indicate the mmendations expressed council meetings had been soussed with residents to nees had been remedied. n 2/27/14, at 12:58 p.m. with worker (LSW) it was dents concerns expressed at beetings are not documented o The LSW stated that resident to dining are communicated to er to address and follow-up. tated, "The timeliness of the been a long term issue and poss". The LSW confirmed that	t a a a a	244			
	concerns/complain council meeting un	ts from the previous resident less the residents bring the he confirmed they had no	711	Eccili	ty ID: 00755	If continuet	on sheet Page 9 of 42

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MAR 2 7 2014

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 overconderd and the cover "sharted during the cover during meal times. The DM also acknowledged that the tuna melts served for supper on 2/26/14, had been			AND HUMAN SERVICES				FORM	: 03/14/2014 APPROVED .0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. 2IP CODE GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE STREET ADDRESS. CITY. STATE. 2IP CODE (M) D SUMMARY STREMENT OF DEFICIENCIES. (EACH DEFICIENCY MUSTE REPEACED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) D 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 occurs are reviewed at the Quality Assurance (QA) quarterly meetings and that in the past the QA committee had implemented a resident food committee had that dimig compliants had subsequently "divinica", hence, the committee was eventually discontinued. The LSW further stated the food committee had met from 8/8/11 unil 4/19/12, and it could be reinstated and "revemped" if necessary. During interview 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 orgen serving is acceptable because all residents tool be present in the ding room at 100 pum, "and everypody can't be first". The DM sonfirmed that only two dietary staff are routingly responsible for serving root to all of the residents was upper on 2/26/14, had been overcooked and the cock "should have stated 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".							(X3) DAT CON	E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDESS CITY STATE_IP CODE GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE STREET ADDESS CITY STATE_IP CODE (MI) ID PRETX TVAS SUMMARY STATEMENT OF DEFICIENCIES (SUCH DEFICIENCY SUBJET & PRECEDED BY TULL REGULATORY OF USED ENTITYING NEORALINON) PREVIDERS PLAN OF CORRECTION IEXACI OCORRECTIVA ATOTION PROVIDE (SUCH DEFICIENCY SUBJET & PRECED BY TULL REGULATORY OF USED ENTITYING NEORALINON) PREVIDERS PLAN OF CORRECTION IEXACI OCORRECTIVA ATOTION PROVIDE (SUCH DEFICIENCY SUBJET & PRECED BY TULL REGULATORY OF USED ENTITYING NEORALINON) PREVIDERS PLAN OF CORRECTION IEXACI OCORRECTIVA ATOTION PROVIDE CORRECTIVA ATOTION PROVIDE IEXACI OCORRECTIVA ATOTION PROVIDE CORRECTIVA ATOTION			245549	B. WING			02	/27/2014
GOOD SAMARTIAN SOCIETY - MOUNTAIN LAKE MOUNTAIN LAKE, MN 55159 (M) ID PREEX TAS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCIES) (EACH DEFICIENCY MUST RE AFRONTIANT ON DECORRECTION (EACH DEFICIENCIES) (EACH DEFI	NAME OF F	PROVIDER OR SUPPLIER	X					······································
PREFIX TXG (EACH CORRECTME ADTION SHOLLD BE REQUATION YOR US UNDENTIFYING INFORMATION) PREFIX TXG (EACH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CENCH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (EACH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CENCH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (EACH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CENCH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (EACH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CENCH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (EACH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CENCH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (EACH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE DEFICIENCY (EACH CORRECTME ADTION SHOLLD BE DEFICIENCY (EACH CORRECTME ADTION SHOLLD BE CROSS-REFERENCED TO THE DEFICIENCY (EACH CORRECTME ADTION SHOLLD BE DEFICIENCY (EACH CORRECTME ADTION SHOLLD BE DEFICI	GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE					
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 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 2/26/14, 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 unsual stating, " We've watched tapes to 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 twat 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 overcocked 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".	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF	X (EAC	CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPI	ULD BE	COMPLETION
to be served".		system to follow up from one meeting to the resident counci- at the Quality Assu- and that in the past implemented a resid- dining complaints h- hence, the committed discontinued. The committee had mer- it could be reinstated necessary. During interview on dietary manager (D during the supper r the residents was u- indicated this was u- indicated the supper r the DM stated that half hour wait time because all resident dining room at 5:00 be first". The DM of staff are routinely re all of the residents utilized to assist wite times. The DM also melts served for su- overcooked and the over". The facility form title Service/Dining Ope- included: "Open dir	with the concerns expressed o the next. The LSW stated I meeting notes are reviewed rance (QA) quarterly meetings the QA committee had dent food committee and that ad subsequently "dwindled", ee was eventually LSW further stated the food from 8/8/11 until 4/19/12, and ed and "revamped" if 2/27/14, at 1:11 p.m. the M) confirmed the wait time heal on 2/26/14 for some of p to an hour. The DM inusual stating, " We've and we've never found vait time was over a half hour." during the evening meal a for meal service is acceptable ts tend to be present in the p.m., "and everybody can't onfirmed that only two dietary esponsible for serving food to and that no other staff are h food service during meal a cook "should have started ed, Guidelines Meal n Dining, revised 8/12 ing includes the following:	F	244			1
	FORM CMS-25	to be served".		1		16		

		AND HUMAN SERVICES					FORMA	03/14/2014 PPROVED)938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY
		245549	B. WIN	IG			02/2	7/2014
NAME OF F	PROVIDER OR SUPPLIER	······		ST	REET ADDRESS, CITY, STATE, 2	ZIP CODE		
				74	5 BASINGER MEMORIAL DR	IVE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		м	OUNTAIN LAKE, MN 5615	59		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	II PRE TA	FIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 244	The facility procedu	ure titled, Grievances,		244				
	included: 2. When a residen staff member expre	ncerns, revised January 200 It, family member, visitor or esses a concern or grievand		-				
	services, it will be r non-judgmental ma discrimination or re 3. If the problem	prisal. can be resolved immediate	ly,				-	2014 2014 2017 2017
	information and pro that problem. The documented on the	vill thank the individual for the poceed to take action regarding grievance will then be Suggestion or Concern (G ad to the center social service	ng ISS					
	director. 4. If the complain services departmer services will comple	It comes directly to the soci nt, then the director of socia ete a Suggestion or Concer upon receipt of the complain	al il m					- 194 11 - 194 11 - 1945 11 - 1945 11 - 1945 11 - 194 11 - 194 1
	5. The social serv Suggestion or Conc appropriate departr reasonably possible	ices director will route the cern (GSS #213) to the ment head as soon as is e						
	grievances. The in but must be thorou persons an opportu relevant to the com	n must be completed for all nvestigation may be informa gh, affording all interested unity to submit evidence nplaint vices director will then repor	•	,				
	the findings to the i and to the center a 8. If the grievance social services dire directly to the admi	individuals filing the concern	n rn d	an an anna an Anna an Anna an Anna Anna				
FORM CMS-2	danger will be hand supervisor. The we	dled by the weekend eekend supervisor will then action to start an investiga	tion	Fac	ility ID: 00755	If continuat	ion sheet P	age 11 of 42

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 03/ FORMAPP OMB NO: 093	ROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	₹VEY ED
		245549	B. WING _		02/27/2	014
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP (ODE	
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE CON	(X5) MPLETION DATE
F 244	Continued From pa and notify the nece	age 11 ssary personnel. It is	F 24	44	- 4, - - 	at 42
	recommended that be forwarded to the within two working	non-threatening concerns will e social worker and resolved days ; and				
	confidential file of c	ices director will maintain a locumented concerns and actions to the quality				(1)14 6
F 253 SS=D	MAINTEÑANCE S	ERVICES	F 2	53 F253 HOUSEKEEPING MAINTENANCE SERVI		
	maintenance servi	ovide housekeeping and ces necessary to maintain a nd comfortable interior.		Resident #13 had a pers which was brought in at admission which was the the odor problem in the	the time of e source of room. This	
e La di La Caulo Ad	by: Based on observa review the facility f			chair is a family heirloon very special to this resid chair has been removed resident has been provid	ent. The and the	4-QK
• •	manner by ensurin of 2 resident room	naintained in a comfortable g odors were addressed for 2 s (R13 & R48) that had a present throughout the survey.		another chair. Family is have the chair cleaned c eliminate any odors. Th bathroom has been clea	or altered to e resident's	· · · · · · · · · · · · · · · · · · ·
	Findings include:			some personal items wh kept in the bathroom hav	1	
	2/26 and 2/27/14, 1	lay of the survey 2/24, 2/25, here was a strong urine odor sent in R13 and R48's nrooms.		removed. Resident # 4 indwelling catheter but h which cause the cathete times. The resident is e	l8 has an as spasms r to leak at ncouraged	nije se Serven
	Interview for Menta completed on 11/2	eviewed. According to a Brief al Status (BIMS) assessment 2/13, R13 had a score of 15/15 e resident's cognition was intact		to continue to drink adeo to decrease the concent urine, the catheter bag is changed several times e	ration of s being ach week,	
	and the resident w	as interviewable. R13 was not odor smell in the room but did		bedding is changed dail peri care is being done.	ı, and good	
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: EVOZ	11	Facility ID: 00755	continuation sheet Page	e 12 of 42

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· • • •

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY
		245549	B. WING		02/	27/2014
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		•
				745 BASINGER MEMORIAL DRIVE		
SOOD SA	AMARITAN SOCIETY	- MOUNTAIN LAKE	1	MOUNTAIN LAKE, MN 56159		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)		COMPLÉTI DATE
F 253	Operations of Freeman		F 050			
F 200	Continued From pa	-	F 253			
		ot want visitors in the room with		Nursing staff were educated o	n	
		Although the administrator		3/6/14, 3/13/14 and 3/20/14 or		
		odor could have originated		need to identify odors, search		
		personal chair located in the vare if an attempt had been		source and eliminate the source		
		sonal chairs and/or if the origin		soon as possible. A walk through		
1		en determined. It was noted		the building was done to deter	•	
		also present in the bathroom.		there were any other areas wit		10000
				urine odor. A periodic walk th		
	When interviewed	on 2/26/14, at 1:00 p.m.		•	•	i terrete
		NA)-D stated, " They have tried		and audit for odors will be don		
		irine odor] with spray but it still	, ,	weekly by the Environmental S		
-		told us to just spray the room		Manager or his designee for th		
		' NA-D showed the surveyor		2 months and then monthly fo		
		to spray in the room. The		next 3 months. Results of the		
		ct indicated it was called,		will be presented at the month		
-	Tuscan garden ode	or counteractant.		Quality Assurance Meeting an		
	During interview wi	ith the director of nursing	, 1	further action, if necessary will		
		on 2/26/14, the DON verified		determined by the interdisciplin	nary	
		aware of the odor in R13's		team.		3/
		It has been a problem since		Completion Date: 3/20/14		120
	she [R13] came he					/
	During an environr	nental tour with the				
		director of environmental	-			
		2/27/14 at 2:30 p.m., a strong	and and a second s			
		served in R48's room. The	1			
		ced in the hallway. During the	The second se			
-		tor and DES verified the odor.				
		facility did not have a policy for				
	urine odor control.					-
		eviewed. According to the				
		een assessed to have severe				
	cognitive impairme interviewed.	nt as not able to be	: 2 1	• • •		
·· :	During on interview	with the DON on 2/27/14, at	4			

MAR 27 2014

					1	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245549	B. WING		02/	27/2014
NAME OF I	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 253	2:00 p.m., the DON in R48's room could	I stated the urine odor present d be due to the resident's use ter, but agreed that odor	F 253	3		
F 282 SS=D	483.20(k)(3)(ii) SEI PERSONS/PER C/	RVICES BY QUALIFIED ARE PLAN	F 282	2		
engli States Materia States States	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of				
	by: Based on observa review, the facility f as defined in the pl	NT is not met as evidenced tion, interview and document ailed to provide oral hygiene an of care for 1 of 3 residents were dependent upon staff for		•		
	Findings include:					
	dated 2/26/14, indic care deficit related	d was reviewed. The care plan cated R4 had a problem of self to weakness and limited entions included the need for I care twice daily.				
	indicated R4 had a included multiple so quarterly Minimum 11/27/13, identified for Mental Status (I indicating intact cos	of the face sheet in the record dmission diagnoses which clerosis and neuropathy. The Data Set (MDS) dated I that R4 had a Brief Interview BIMS) score of 15/15, gnition. The MDS also eding total assist from staff				

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		AND HUMAN SERVICES			FO	TED: 03/14/2014 ORM APPROVED
		& MEDICAID SERVICES	<u> </u>			NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		245549	B. WIN	G		02/27/2014
NAME OF F	PROVIDER OR SUPPLIER	L		l s	TREET ADDRESS, CITY, STATE, ZIP CODE	
					45 BASINGER MEMORIAL DRIVE	
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			IOUNTAIN LAKE, MN 56159	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION E DATE
F 282	Continued From pa	ge 14	F	282	F282 SERVICES BY QUALIFIED PERSONS PER CARE PLAN	
· .	was noted that R4 h	on 2/25/14, at 11:06 a.m. i nad no upper teeth and the ired dirty with debris. R4			Resident #4 had been refusing ora care from some staff. The residen was interviewed and assessed to	
	stated during interv not brush her teeth	iew at that time that staff d daily. R4 said the staff bru			determine why she declined oral care from some staff and how we	
	reported that staff h	ice a week and further had not brushed her teeth t			could modify the procedure so she would accept this and have	
	-	r that morning during cares on 2/26/14, at 1:48 p.m. R			satisfactory oral hygiene. Modifications were added to her	
- -	lower teeth had what	at appeared to be a build-u stated her teeth had not be	ip of		care plan and nursing staff were educated on 3/6/14; 3/13/14, and 3/20/14 to how this resident would	ait a
	R4 stated her teeth	th R4 on 2/27/14 at 9:00 a. were not brushed the prio			like to have her oral care performer and also on the need and importance of good oral hygiene fo	
	good one" and that cares were provide	es. R4 stated NA-A was "a she brushed her teeth whe d. R4 again stated, "they	en		all residents. Staff were directed to notify the Case Managers of any refusals of care so residents could	D
	other staff).	nce a week" (reference to			be assessed for the reason for refusal and modifications made to	
	a.m., NA-A stated s	th NA-A on 2/27/14, at 9:30 she always brushes R4's te wided. However, NA-A sta	eth		their care plans. All other residents were assessed for adequate oral	S
	she doesn't work w	ith R4 that often.			hygiene. Residents will be monitored by the Director of Nursir or her designee for adequate oral	ng
	2/27/14, at 8:53 a.n	th registered nurse (RN)-A n., RN-A verified the NAs w e oral cares during morning	vere		hygiene 2-3 residents per week x one month and then 2-3 residents	
	and evening cares. cognitively intact ar	RN-A confirmed that R4 v nd could accurately report			per month x 3 months. Results of these audits will be presented at th	1
	defined on the plan				monthly Quality Assurance meeting and any further action, if necessary will be determined by the	-
	(DON) on 2/27/14,	th the director of nursing at 10:05 a.m. she stated th at staff would follow the	ne		interdisciplinary team. Completion date: 3/20/2014	3/20/14
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID:	EVOZ11	Fac	cility ID: 00755 If continuation s	heet Page 15 of 42

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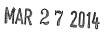
MAR 2 7 2014

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
			:			
	245549 NAME OF PROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	02/27/2014	
	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	1997 - 1997 1997 - 1997 1997 - 1997 - 1997 1997 - 1997 - 1997	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 282	the morning and the verified that R4 was	ge 15 and provide oral care both in e evening. The DON also s cognitively intact and would orting whether oral cares had	F 28	2		
F 312 SS=D	•	ARE PROVIDED FOR IDENTS	F 31	2		
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal			1997 - 1997 1997 - 1997 - 1997 1997 - 1997 - 1997 1997 - 1997 - 1997 1997 - 1997 - 1997 - 1997 - 1997 - 1997 1997 - 1977 - 1977 - 1977 -	
· · ·.	by: Based on observa review the facility fa maintain oral hygie	NT is not met as evidenced tion, interview and document ailed to provide services to ne for 1 of 3 residents (R4) dependent upon staff for oral	,			
	Findings include:					
	sheet indicated R4	d was reviewed. The face had admission diagnoses ltiple sclerosis and neuropathy.				
	11/27/13, identified for Mental Status (I indicating intact co- identified R4 as ne with grooming. The indicated R4 had a related to weakness	num Data Set (MDS) dated d that R4 had a Brief Interview BIMS) score of 15/15, gnition. The MDS also eding total assist from staff e care plan dated 2/26/14, problem of self care deficit s and limited mobility, and the led the need for total assist				

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		AND HUMAN SERVICES		FORM	: 03/14/2014 1APPROVED . 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY	
245549		B. WING	02	/27/2014	
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
			7	45 BASINGER MEMORIAL DRIVE	
GOOD S.	AMARITAN SOCIETY		N. Contraction	MOUNTAIN LAKE, MN 56159	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	with oral care twice During observation was noted that R4 bottom teeth appea stated during interv not brush her teeth her teeth maybe or reported that staff h previous evening o During observation lower teeth had wh white material. R4 brushed "last night During observation nursing assistant (I morning cares for h brush R4's teeth. During additional in 9:00 a.m., R4 state the prior evening d was "a good one" a when cares were p "they might brush t to other staff). During interview wi a.m., NA-A stated s	daily. on 2/25/14, at 11:06 a.m. it had no upper teeth and the ared dirty with debris. R4 iew at that time that staff do daily. R4 said the staff brush ace a week and further had not brushed her teeth the r that morning during cares. on 2/26/14, at 1:48 p.m. R4's at appeared to be a build-up of stated her teeth had not been or this morning." on 2/27/14 at 8:16 a.m., NA)- A was observed providing R4. NA-A was observed to her teeth were not brushed uring cares. R4 stated NA-A and that she brushed her teeth rovided. R4 again stated, hem once a week" (reference th NA-A on 2/27/14, at 9:30 she always brushes R4's teeth ovided. However, NA-A stated	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	
	During interview wi 2/27/14, at 8:53 a.r expected to provide and evening cares.	th registered nurse (RN)-A on n., RN-A verified the NAs were e oral cares during morning RN-A confirmed that R4 was nd could accurately report	11	monthly Quality Assurance meetings and any further action, if necessary will be determined by the interdisciplinary team. Completion date: 3/20/2014 acility ID: 00755 If continuation shee	3/20/14

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		AND HUMAN SERVICES		n t		FORM	03/14/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245549	B. WING	i		02/2	27/2014
NAME OF F	PROVIDER OR SUPPLIER	• · · · · · · · · · · · · · · · · · · ·			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			45 BASINGER MEMORIAL DRIVE IOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	defined on the plan	had brushed her teeth as of care.	F:	312			
F 323 SS=D	(DON) on 2/27/14, expectation was the resident's care plan the morning and th verified that R4 was		F	323			
	environment remai as is possible; and	nsure that the resident ns as free of accident hazards each resident receives on and assistance devices to					
	by: Based on observa review, the facility f risk associated with effectiveness of fal residents (R13 & R accidents and also temperatures in res R22, R36, R42, R4 maintained within a	NT is not met as evidenced tion, interview and document ailed to effectively analyze the falling and to monitor the l interventions for 2 of 4 (23) who were reviewed for failed to ensure that hot water sident bathrooms (R3, R13, (3, R48, R65 and R102) were a safe range and this had the of 16 resident bathrooms iter temperatures.					
FORM CMS 24	67(02-99) Previous Versions	s Obsolete Event ID: EVOZ1		Fac	cility ID: 00755 If continuat	ion sheet	Page 18 of 42
	UL-UL FIENDUS VEISION			rat	n continuat	ion sheet	, age 10 01 42

MAR 27 2014

						PF	RINTED: 0	
	MENT OF HEALTH				•			PROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO	PPLIER/CLIA	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE S COMPLE	URVEY
		2455	549	B. WING			02/27	/2014
	PROVIDER OR SUPPLIER	1		I	STREET ADDRESS, CITY	STATE ZIP CODE	ULILI	12014
					745 BASINGER MEMO			e ta s
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAI	<Е 		MOUNTAIN LAKE, M	IN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETION DATE
				1				er an
F 323	Continued From pa	ige 18		F 32	3		۰. ۱	1997 -
		-			F323 FREE OF			
	R23 experienced a	fall on 12/17/13	at 12:35		HAZARDS/SUF			11 y 1
	a.m., three hours a					& 23 have been		
	receiving Ativan 0.5					oossible risk facto	ors	
	12/16/13, at 9:15 p.					s for falls have be		
	fall on 12/31/13,at minutes after receiv					dications have be		
	at 9:30 p.m. R23 e					ontinued monitori		1 - 1 1 - 1 - 1
	1/12/14, at 1:15 a.r				in place. All su	bsequent falls ha	ive	
	two days prior on 1					for root causes.		1.2211.
	receive Oxycodone					lited to assure all		• •
	whenever necessa				1	en assessed by		
	physician order and		pain			sing or her desigr		1996 (B. 1
	medication prior to	the three fails.				nonths. Results of		
	R23's active diagno	osis from the Mir	imum Data			II be reported at t		
	Set (MDS)form dat					y Assurance mee		
	limited to, hyperten				and any further	r action, if necess	ary	
	anxiety and depres				will be determin		arus - Al Manganer	i i i i i i
	indicated a history	of falls 2-6 mont	hs prior to		interdisciplinary	y team.		
	admission.				Water heaters	were adjusted at	the	. mane
	R23's Brief Intervie	w for Montal Sta	tue (PIME)		time of the surv	vey and water ter	nps	
	dated 12/10/13, in					nave been checke		
	out of a possible 15		*			Nater temperatur	es	
		. J			are being moni			
	R23's plan of care				1	Services Directo		
	"Comfort: Alteration					n all wings at leas		
	(degenerative joint					e sure temps are		
	chronic low back pa					ge. Audit results		
	being difficult to ma approaches read, "					at the monthly Qu		• . * .
	when having sig (si	•				mmittee meetings		
	The plan of care da			-	-	ion, if necessary	WIII	
	"Mood/behavior; Al				be determined	•		
	anxiety, dementia,				interdisciplinar	-	-	3/
	combative, shoutin				Completion da	ite: 3/20/14		120/14
	admission here, als							. Ent
	pain." The plans ar							
FORM CMS-25	67(02-99) Previous Versions	s Obsolete	Event ID: EVOZ1	11	Facility ID: 00755	If continuati	ion sheet Pa	ge 19 of 42

STATE DEFUNCTION (X) PROVEENSUPPLIENCIAL DEMTIFICIAN NUMBER: (X) PROVENSUPPLIENCIAL DEMTIFICIAN NUMBER: (X) P			AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	03/14/2014 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER SIMPLER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE STREET-ADDRESS, CITY, STATE, LIP CODE TAB BASINGER MEMORIAL SIRVE MOUNTAIN LAKE, MN 56159 PALL TAG SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCES DURY TOUL REQUESTION NUSTEE RECENT OF DURY OF DEFICIENCES (EACH DEFICIENCY NUSTEE RECENT OF NUSTE RECENCED BY YUL REQUESTION NUSTEE RECENCED BY YUL REQUESTION NUSTEE RECENCED BY YUL REQUESTION NUSTEE RECENCED BY YUL REQUESTION NUSTEE RECENCED BY YUL RECENCED TO THE APPROPRIATE DURY OF DURY OF DURY OF DEFICIENCES and procedures, esp (especially) when annous or experiencing pain. X(example) behavior, calls out or holies, inquire about res pain level and report to runse. If the section for communication the plan of care read, "Deficit in cognitive changes R/T dementa, also has a history of confusion, agitation, anxiety with increased pain level causing difficulty with comprehension." R23S plan of care addressed the potential for adverse consequences R/T current medication. R23S ind or a diverse of all medications. When interviewed on 2227/14, at 9:30 a.m. the directed staff to monitor for adverse consequences R/T current medication regime and directed the staff to monitor for adverse consequences R/T current medication regime and directed the fail. Information was not available related to the procipitating factor associated with the resident and including: toleting, positioning, pain medication use and observation of anxiety level prior to the three fails. The document titled, "Fallen or Injured Resident," directed staff to. "Complete the Incident Report, and the Fails Data Collection tool and to lock for differences that may indicate a change in the risk for fails and to further explore risk factors and to assist in planning for resident safey." The forms were not completed, the plan of reare was not updated and the facility failed to summarize all three	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
IMME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STRE. 2P DODE COOD SAMARITAN SOCIETY - MOUNTAIN LAKE INTERCIDENT SUPPLIER CMUID SUMMARY STREMENT OF DEFICIENCIES THE SUMMARY STREMENT OF DEFICIENCIES FAD SUMMARY STREMENT OF DEFICIENCIES PREFIX TAG Continued From page 19 F 323 TAG Continue from page 1			245549	B. WING			02/2	7/2014
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE MOUNTAIN LAKE, MN 56159 (X4) D PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDER BY TULL) REGULATORY OF LSC DENTIFICING INFORMATION) D PRETIX TAG PROVIDERS FLAM OF CONRECTION (EACH DEFICIENCY MUST BE TREACEDER BY TULL) REGULATORY OF LSC DENTIFICING INFORMATION) D PRETIX TAG PROVIDERS FLAM OF CONRECTION (EACH DEFICIENCY MUST BE TREACED BY TULL) 0,05 (EACH DEFICIENCY TAG 0,05 (EACH DEF	NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE		n en
PREFix TxG LEACH DEPICENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTRYING INFORMATION) PREFix TxG TaG CROSS-REFERENCE OT OTHERADOR SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMMETTION DEFICIENCY 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, "Definit in cognitive changes RT dementia, also has a history of confusion, agitation, anxiety with increased pain level causing difficulty with comprehension." R23s plan of care addressed the potential for adverse consequences RT current medications. F 323 When interviewed on 2/27/14, at 9:30 a.m. the director of nursing (DON) verified the three fails for R23 did not address any precipitating events to help prevent future fails which include the activity R23 had experienced prior to the fail. 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 fails. The document titled, "Failen or injured Resident," directed staff () "Complete the Incident Report, and the Fails Data Collection tool and to look for differences that may indicate a change in the risk for fails 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 fails were around 1:00 a.m. and an intervention should have been put into place following the use of Ativan for R23. S	GOOD S.	AMARITAN SOCIETY	- MOUNTAIN LAKE					
 " 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 eausing 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; tolleting, positioning, pain medication 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 faelity falled to summarize all three falls were around 1:00 a.m. and an intervention should have been put into place following the use of Atwar for R23. 	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX (EACH CORR	ECTIVE ACTION SHOULD ENCED TO THE APPROPI	BE	COMPLETION
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	" Explain purpose of and procedures, es experiencing pain. out or hollers, inqui report to nurse." In the plan of care rea changes R/T deme confusion, agitation level causing difficu R23's plan of care adverse consequer regime and directed adverse consequer When interviewed of director of nursing	of your visit as well as cares sp (especially) when anxious or X/(example) behavior; calls re about res pain level and the section for communication ad, "Deficit in cognitive antia; also has a history of n, anxiety with increased pain ulty with comprehension." addressed the potential for nees R/T current medication d the staff to monitor for nees of all medications. on 2/27/14, at 9:30 a.m. the (DON) verified the three falls	F	323			
ECRM CMS_2567/02_99) Previous Versions Obsolete Event ID: EVO711 Facility ID: 00755 If continuation sheet Page 20 of 42		to help prevent future activity R23 had exception was not precipitating factors and including: toiled medication use and prior to the three factors and the falls Data differences that may for falls and to further assist in planning for were not completed updated and the factors and the falls were arc intervention should following the use of During the environt	The falls which include the perienced prior to the fall. It available related to the sassociated with the resident eting, positioning, pain dobservation of anxiety level lis. d, "Fallen or Injured Resident," complete the Incident Report, Collection tool and to look for ay indicate a change in the risk her explore risk factors and to for resident safety." The forms d, the plan of care was not cility failed to summarize all bund 1:00 a.m. and an have been put into place f Ativan for R23.					
	EORM CMS 2	<u> </u>		 11	Facility ID: 00755	If continuat	ion sheet F	Page 20 of 42

MAR 27 2014

		AND HUMAN SERVICES				FORM	03/14/2014 APPROVED
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION	(X3) DATI	0938-0391 E SURVEY IPLETED
		245549	B. WING	;		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER	E			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	checked in a variet each wing at the be end of the wing and Temperatures were noted in the followin (1) Resident 100 w R43-122 degrees, (2) Resident 200 w 124 degrees, R22- degrees; and (3) Resident 300 w R65-123 degrees. Interview with the a maintenance on 2/2 recommended fede 120 degrees for do maintenance share hot water heater in weeks ago, maybe heater was put in." verified the water to checked since the installed. The facility policy ti Temperature/Hardr 2006 read, "These and recorded a min needed or required would be laundry, b per wing."	vices, water temperatures were y of resident bathrooms on eginning of the wing and the d on each side of the wing. e record as Fahrenheit and ng areas: ing: R102-123 degrees, R48-124 degrees; ving: R3- 123 degrees, R13- 122 degrees, R36- 122 ing: R42-125 degrees and administrator and director of 27/13, at 9:30 a.m. verified the eral temperatures can go up to mestic water. The director of ed that the facility had a new stalled and stated, "A couple of a month since the hot water The director of maintenance emperatures had not been new hot water heater had been tled, "Water ness Record" dated November checks should be completed nimum weekly or more often if I. Recommended check areas kitchen and one resident room		323			
	resident burns asso temps.	ociated with the hot water					

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: EVOZ11

Facility ID: 00755

If continuation sheet Page 21 of 42

		& MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245549	B. WING		02/27/2014
NAME OF F	ROVIDER OR SUPPLIER	1	l	STREET ADDRESS, CITY, STATE, ZIP CODE	
	·			745 BASINGER MEMORIAL DRIVE	. •
GOOD S.	AMARITAN SOCIETY	- MOUNTAIN LAKE		MOUNTAIN LAKE, MN 56159	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	ILD BE COMPLETI
F 329	483.25(I) DRUG R	EGIMEN IS FREE FROM	F 32	F329 DRUG REGIMINE IS FF 9 OF UNNECESSARY DRUGS	
SS=D	UNNECESSARY D	DRUGS		Resident #46, who is on Proza	ac, •
	Each resident's dru	ug regimen must be free from		was assessed and physician contacted. The physician has	
	unnecessary drugs	An unnecessary drug is any		written his rationale for his des	sire to
		excessive dose (including		continue the use of the Proza	
		or for excessive duration; or	-	this resident. Res #23 had no	
		nonitoring; or without adequate se; or in the presence of		the Ativan since January and	
		nces which indicate the dose		medication was discontinued	by the
		or discontinued; or any		physician. All other residents	
	combinations of the			similar drugs have had their	
				medications reviewed and the	ir
		ehensive assessment of a		physicians have been notified	if
		y must ensure that residents I antipsychotic drugs are not		necessary for dose reductions	
		unless antipsychotic drug		the physician to explain the ra	
		ry to treat a specific condition	78646 V V V V V V V V V V V V V V V V V V	for continued use. All orders	
	as diagnosed and	documented in the clinical		medications will be monitored	
÷.,		nts who use antipsychotic		their continued use and indica	
1.4		ual dose reductions, and		use and their physicians will b	
		tions, unless clinically an effort to discontinue these		notified if necessary. The Dir	
	drugs.	an enore to discontinue these		Nursing or her designee will a	
	arage.			the medications regimen of th residents taking psychoactive	
				medications to determine if th	
				an appropriate dose reduction	
				current physicians rationale for	
		NT is not met as evidenced		continued use on 4 residents	
	by:			times one month and then 4	-
	Based on intervie	w and document review the		residents monthly for 3 month	ns. All
		sure 2 of 5 residents' (R46 and	1441 - 1 1	results of these audits will be	
		s were free from unnecessary		reported at the monthly Quali	
	gradual dose reduced	facility staff failed to attempt a	1 - -	Assurance meeting and any f	urther
		dication, failed to provide		action, if necessary will be	
		ued usage, and failed to		determined by the interdiscip	linary
	ensure adequate n	nonitoring was conducted for	,	team.	3/21
	the use of an antia	nxiety medication.		Completion date: 3/20/14	[a0]

MAR 2 7 2014

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

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

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245549	B. WING	i		02/	27/2014
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE	1	7	TREET ADDRESS, CITY, STATE, ZIP CODE 45 BASINGER MEMORIAL DRIVE IOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From pa	age 22	F	329			
	Findings include:						
	indicated the reside 5/3/11 with diagnos physician orders in restarted on Proza mouth) daily on 2/2 Patient Health Que used to determine 12/11/13, indicated indicating no sign/s depression.	reviewed and the face sheet ent had been admitted on ses including depression. The dicated R46 had been c 10 mg (milligrams) po (by 25/13. Review of the quarterly estionnaire (PHQ-9)- a tool potential mood problems dated d that R46 scored a zero (0) symptoms related to	•		•	:	
	identified R46 had behavior related to anxiety, and increa complaints of not f Care plan approac through 2/25/14, in	an alteration in mood and episodes of withdrawal, ased confusion as evidenced by eeling well and tearfulness. thes reviewed from 8/31/13 indicated R46 had no episodes eneral physical complaints					
	form from the cons 8/10/13, included: is due for: Prozac dose response obs depressive/demen reduction if no long	avior-Medication monitoring sulting pharmacist, dated "Six month drug re-evaluation 10 mg daily. Please document served for controlling target tia symptoms or attempt dose ger needed". The form lacked response from either the e physician.					
	director of nursing had not attempted	n 2/27/14, at 1:45 p.m. the (DON) confirmed the physician a GDR or provided rationale d continue on the medication					Page 23 of 42

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: EVOZ11

Facility ID: 00755

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MAR 2 7 2014

		AND HUMAN SERVICES & MEDICAID SERVICES				RINTED: 03 FORM API MB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SU COMPLE	RVEY TED
		245549	B. WING			02/27/2	2014
NAME OF F	PROVIDER OR SUPPLIER	I	·	STREET ADDRESS, CIT	Y, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEM MOUNTAIN LAKE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROP DEFICIENCY)	BE CC	(X5) MPLETION DATE
F 329	The DON confirme monitoring form da pharmacist had not physician for review recommendation. R23's record was m administration reco received Ativan 0.5 at 9:15 p.m. and ha 12/17/13, at 12:35 later). In addition, f received Ativan 0.5 and had experience 1:10 a.m. (3 hours R23's active diagne Set (MDS) form da hypertension, deme depression. This M a history of falls ha to admission. A Bri (BIMS) assessmen R23 had scored 15 R23's current care "Comfort: Alteration (degenerative joint chronic low back p being difficult to ma "Yelling at staff: ofte (significant) pain; m care plan included; R/T depression, ar history of being con berating staff prior	ng the medication on 2/25/14. d the Behavior-Medication ted 8/10/13 from the t been communicated to the	F3	329			
EORM CMS-2	included; " Explain	purpose of your visit as well as ires, esp (especially) when	:	Facility ID: 00755	If continue	tion sheet Pag	ue 24 of 42

MAR 27 2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245549	B. WING			02/2	27/2014
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		1	45 BASINGER MEMORIAL DRIVE IOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	behavior; calls out of pain level and repor- communication sec- included: "Deficit in dementia; also has agitation, anxiety w causing difficulty wi plan of care address consequences R/T and directed the sta consequences of a A review of the doc Monthly Drug Revie conducted and the Problems" on 12/12 indicating no drug p for R23. The form w pharmacist. Physician orders in (mg) was prescribe whenever necessan day. According to WebM drug used to treat a included, "Older ad the side effects of t coordination and dr may not experience lorazepam. It may f elderly, causing syr changes, sleeping interest, or hallucin	ncing pain. X/(example) or hollers, inquire about res rt to nurse." The stion of the plan of care cognitive changes R/T a history of confusion, ith increased pain level th comprehension." R23's seed the potential for adverse current medication regime aff to monitor for adverse		329			
FORM CMS-24	the risk of falling."	; Obsolete Event ID: EVOZ	1	Fa	cility ID: 00755 If continua	tion sheet	Page 25 of 42

		AND HUMAN SERVICES					FORM	03/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245549	B. WING	S		·	02/2	27/2014
NAME OF F	PROVIDER OR SUPPLIER	······		STR	EET ADDRESS, CITY, STATE	, ZIP CODE		
GOODS	AMARITAN SOCIETY	- MOUNTAIN LAKE		745	BASINGER MEMORIAL D	RIVE		
000000				MO	UNTAIN LAKE, MN 561	59		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 329	Continued From pa	age 25	F	329				्रम् सुर्वे
	•	cember 2013 MAR indicated						Cale of
		Ativan 0.5 mg for anxiety						· · · · · ·
	during the following							
		3:30 p.m. given for agitation						
	"calm/resting" at 7	cumentation revealed						
· · · ·		2:35 p.m. for general						
		response to the medication		-				
		t 4:30 p.m. "Resting quietly."	1					
	(3) On 12/16/13, at							
		or administration nor effect ninistration of the medication;						· .
	(4) On 12/18/13, a							
		nor results from receiving the						1770 (41 A
	medication;	9						· · · ·
		9:30 p.m. with no indication or						
		th no results documented;						
		t 2:10 p.m. Ativan given for general pain/restless'' with						· · · · · · · · · · · · · · · · · · ·
		king to indicate the response to						
	the medication; and		· ·					
	(7) On 12/30/13, a	t 9:30 p.m. Ativan						
an Artista Artista		ixiety and no resident		-				
	response to the me	edication documented.						
	A review of the Jan	uary 2014 MAR indicated		Ì				
		been given on the following	l					
	dates:		•					
		:30 p.m. administered without	1					
		e nor documented resident						
	response; and (2) On 1/9/14 at 7 ⁻	30 p.m. administered for		Ì				
		umentation describing the						1254
	anxiety symptoms i	nor whether the resident						
	responded to the m	nedication.						
	Documentation	a looking in the record for DOO						
		s lacking in the record for R23 It side effect monitoring for the						
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: EVOZ1	<u>.</u> 1	Facilit	y ID: 00755	If continuati	on sheet I	Page 26 of 42

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	NTED: 03/14/2014 FORM APPROVED B NO: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(3) DATE SURVEY COMPLETED
		245549	B. WING			02/27/2014
NAME OF I	PROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEMOR MOUNTAIN LAKE, M		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	
F 329		ge 26 th the consultant pharmacist a.m., the pharmacist verified	F 3	29		an a
	R23's use of Ativan	was not addressed in the or December 2013, January				
F 364	2/27/14, at 9:30 a.n been no recommen regarding R23's inte Ativan without adec monitoring of the m 483.35(d)(1)-(2) NL	th the director of nursing on n., the DON verified there had idations from the pharmacist ermittent use of the medication quate indications for use and/or iedication's effectiveness. JTRITIVE VALUE/APPEAR,		64		
SS=E	food prepared by m	ves and the facility provides nethods that conserve nutritive ppearance; and food that is				
	by: Based on observat failed to provide me attractive for 7 of 52	NT is not met as evidenced ion and interview the facility eals that are palatable and 2 residents (R10, R13, R33, 65) who were served meals.				
	Findings include:					
	expressed dissatisf the facility stating, " good and sometime subsequent observa	2/25/14, at 10:14 a.m. R10 action with the food served at It's edible; sometimes it's very es it's very poor". During ation/interview on 2/27/14, at red the tomato soup she was				
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: EVOZ1	1	Facility ID: 00755	If continuation	sheet Page 27 of 42

MAR 2 7 2014

PRINTED: 03/14/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245549 B. WING 02/27/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE **GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE** MOUNTAIN LAKE, MN 56159 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRFFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F364 NUTRITIVE VALUE / F 364 Continued From page 27 F 364 **APPEARANCE / PREFERED** served for supper on 2/26/14 was "not verv TEMPS good". R10 further stated she sent back the tuna

The quality and the temperature of melt sandwich that was served as it was burnt. the food has been evaluated for Documentation on the Brief Interview for Mental Status (BIMS), dated 2/13/15 indicated R10 was improvement. Dietary staff were cognitively intact and had a score of 15/15. educated on 3/4/14 & 3/19/14 on the need to provide food that is properly When questioned about the meal on 2/25/14 at cooked, remains moist and is served vy.) 5:39 p.m., R13 was unable to identify the meat at the proper temperature. At least 2 391 she had been eating and stated, "I don't know menu choices continue to be offered what this is, I really don't, it is so dry." at each meal for those with specific R13 had a BIMS score on 11/27/13, of 15/15 likes and preferences. A Food which indicated cognitively intact. Committee has been established During interview on 2/26/14, at 5:44 p.m. R31 with representation from Residents, stated the food served "isn't very good". While Nursing, Dietary, Activities, and R31 awaited her meal, she pointed at her Social Service. This committee has tablemate's (R51) sandwich and stated, "I hope met on 2 occasions, on 3/17/14 & mine's not like that". The bread on R51's tuna 3/20/14 and will continue to meet at melt sandwich was noted to be a dark brown to least monthly to explore all issues black in color and appeared burnt. R31 indicated associated with the dining that one day when the planned meal was experience including how meals are supposed to be meatloaf, meatballs were served scheduled, menu choices and ways instead, "and they were burnt". R31 further stated she had been served soup recently that foods are served and presented. had so much pepper seasoning added that "It Each resident that is able to be burnt my throat going all the way down". interviewed will be polled to determine their preferences and During a subsequent interview on 2/27/14, at allow them input into any changes 11:45 a.m. R31 stated that when her meal was that might be made by this Food finally served the night before, she received Committee. The Dietary Manager or tomato soup which she sent back to the dietary her designee will audit meals for department, stating, "I can't eat tomato soup". R31 was offered minestrone soup which she quality and proper temperature on at least 3 meals per week for the first declined and then staff found a can of vegetable soup and that was "ok". R31 had a BIMS score month and then 1 meal per week for on 1/16/14 of 15/15 indicating she was cognitively the next 2 months.

Completion Date: 3/20/14

FORM CMS-2567(02-99) Previous Versions Obsolete

intact.

Facility ID: 00755

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MAR 2 7 2014

	IMENT OF HEALTH							RINTED: 03 FORM AP MB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLI IDENTIFICATION N	ER/CLIA		TIPLE CONST			(X3) DATE SU COMPLE	JRVEY
		245549		B. WING				02/27/	2014
NAME OF	PROVIDER OR SUPPLIER	L			STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE				NGER MEMORIA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCI / MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG		EACH CORRECTIN	AN OF CORRECTIO VE ACTION SHOULE ED TO THE APPROP ICIENCY)	BE C	(X5) OMPLETION DATE
F 364	Continued From pa During interview on stated, "The food is R33 further stated the quality of the fo food being too cold indicated that abou were served meath been "taken off of s were people who u food that were com further stated, "The R33 confirmed the and stated although sprig of green on th appearance. R33 fo f 15/15 which indic intact.	2/26/14, at 2:30 p.r in't very good here". the timeliness of foc- od and the tempera- was an issue as we t a month ago the re- balls that tasted like some leftover spagh sually don't complai plaining about that" y just plop it on the food did not look a n she doesn't care for the plate would impro- nad a BIMS score o	od service, ture of the ell. R33 esidents they had etti; there n about the . She plate". ppetizing or meat, a ove the n 1/22/14	F 3	64				
	During and intervie expressed dissatist stating, "The food is have it heated up w they serve that bare of improvement in t whether the food ta question I wish you make stuff that tast supposed to have r balls and they were shot. The food is o During an observat following day on 2/2 "The food is always couple weeks ago t meatloaf so I thoug ordered it. I got me could have shot the soup it is so thick th	action with the food s usually too cold. I when we have soup ely warm. There co the kitchen." When sted good he stated had not asked. Th es good. They wer heatloaf but they se hard enough to use vercooked." ion of the evening n 26/14, at 5:45 p.m. F like this. He stated they said they were ht that sounded goo eatballs that were so	served ask to because uld be a lot asked d, "That is a ey don't e rved meat e for a sling heal the R45 stated, d that a having od so I o hard you Look at this						
FORM CMS-2	567(02-99) Previous Versions	Obsolete	Event ID: EVOZ11		Facility ID: 00	0755	If continuat	ion sheet Pag	je 29 of 42

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		AND HUMAN SERVICES & MEDICAID SERVICES	· · · · ·			FORM	03/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245549	B. WING	s		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER	I	L	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			45 BASINGER MEMORIAL DRIVE IOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 364	Continued From pa	age 29	F	364			
	a Brief Interview fo	r Mental Status (BIMS) score which indicated he was					چه از
	expressed dissatis stating, "Today at lu the chicken breast green bean casser give you your yogu omelet on a cold pl	a 2/24/14, at 12:50 p.m. R53 faction with the food served unch the noodles were cold, was dry with no gravy and the ole was not good. They will rt on a hot plate and your ate! The food is usually not the They keep saying they are doesn't change".					
	2/26/14, at 5:50 p.r her table to make r melt which was bla "And I am expected manager was ques in question, she ve	tion of the supper meal on m. R53 called the surveyor to note of the open faced tuna ck on the bottom. She stated d to eat that"? After the dietary stioned regarding the tuna melt rified the sandwich should not and proceeded to find an m for R53.					
	station and stated to sandwich had beer offered me a grilled but at that point I h thought what the he they brought me th was black and the questioned whethe she was sick of it a it. R53 had a BIMS which indicated sh	2 a.m. R53 entered the nursing that after the burnt tuna in returned to the kitchen, "They d cheese which I don't care for ad been waiting an hour and I eck, I'll take anything. Then e grilled cheese and the top cheese wasn't melted!" When in an alternative was offered, and just took the top off and ate is score on 12/25/13 of 15/15 he was cognitively intact.					
	stated, "The food is	on 2/25/14, at 10:09 a.m. R65 s very poor quality because it	:				
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: EVOZ	11	Fa	cility ID: 00755 If continua	tion sheet	Page 30 of 42

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	IMENT OF HEALTH							RINTED: 03 FORM AP MB NO. 09	PROVED
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP		(X2) MUL A. BUILD	TIPLE CONST	RUCTION		(X3) DATE SI COMPLE	JRVEY TED
		2455	49	B. WING			-	02/27/	2014
NAME OF I	PROVIDER OR SUPPLIER	••••••••••••••••••••••••••••••••••••••				DDRESS, CITY, STA			
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAP	ΚE			IN LAKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFI TAG		PROVIDER'S PLAN EACH CORRECTIVE OSS-REFERENCED DEFIC	EACTION SHOULD	BE C	(X5) OMPLETION DATE
F 364	Continued From pa comes out of a true made items here. T beef, otherwise eve out. If the meat is of vegetables are too Just watch the mea see what I mean. V one listens to us." Later, during the no p.m. R65 was serve R65 stated, "Look a overcooked and the was observed durin that R65 was serve vegetables with bro again, overcooked sit there before we the problem with the what you can do ab BIM's score was 16 cognitively intact. During interview or dietary manager (D served the prior eve overcooked and into started over". On 2/27/14, at 12:1 obtained and tested was served by cool immediately after the served to the last re of: beef with gravy baked potato, mixe	ck, there are very The only good me erything is very to chicken, it is dried overcooked with als in the dining re Ve keep complai boon meal on 2/25 ed broccoli and h at this broccoli, it e ham is tough a ng the noon meal ed pork roast and boccoli. R65 state and dried out, ho get it? That has e overcooking, F bout the food here 5/15, which indica a 2/27/14, at 1:11 M) confirmed the ening (2//26/14) v dicated the cook 5 p.m. a test tray d by two surveyor k -A. The food was esident. The me , ham, mashed p d vegetables, ca	eat is the roast bugh and dried lout, and the little flavor. com, you will ning but no /14, at 12:30 ham for lunch. is nd dry." It lon 2/26/14, mixed d, "Here it is ow long does it to be part of Please see e." R65's ated he was p.m. the e tuna melts were "should have y was rs. The food as dished dished and nu consisted otatoes, rrots, ground		364				
	meat (beef) and gro noted to taste very dry, straw-like and	dry and the grou lukewarm. The g	nd ham was ground meat		:				-
FORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: EVOZ1	1	Facility ID: 00	755	If continuati	ion sheet Pag	e 31 of 42

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		AND HUMAN SERVICES & MEDICAID SERVICES			en e	ORMA	03/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE	SURVEY PLETED
•		245549	B. WING		-	02/2	7/2014
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			5 BASINGER MEMORIAL DRIVE DUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 364		ge 31 dry. The mixed vegetables nd the mashed potatoes had	F 3	-	, and the provident of the con-		
F 371 SS=F	483.35(i) FOOD PF	ROCURE, /SERVE - SANITARY	F 3	371	F371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY		
 	considered satisfac authorities; and	om sources approved or tory by Federal, State or local distribute and serve food litions			Areas of the kitchen were cleaned and a new cleaning schedule has been instituted. The dietary staff were educated on 3/6/14 & 3/19/1 on the cleaning schedule and the need to maintain sanitary condition the proper use of gloves and when	l4 ons,	
e di C					to change them, the regulations regarding dating and monitoring dates on perishable items, the new		
	by: Based on observat review, the facility fa dietary kitchen, faile to prevent cross co milk based supplen refrigerator storage under sanitary cond to affect all 52 resid	NT is not met as evidenced tion, interview and document ailed to maintain a clean ed to serve food in a manner ntamination, failed to monitor nents for appropriate and failed to serve foods ditions which had the potential lents who consumed food			to keep foods covered until ready serve and the proper temperature requirements for food that is serve 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	to ed.	
	the following observ (1) Two metal carts splattered with food (2) The cupboard d	our on 2/24/14 at 9:05 a.m. vations included: s in the kitchen that were l debris; oors throughout the kitchen ppeared to have food debris			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	у	3/20/14

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	· · ·	AND HUMAN SERVICES & MEDICAID SERVICES					FORM A	03/14/2014 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE DING	CONSTRUCTION	()	X3) DATE COMPI	
		245549	B. WIN	G			02/27	7/2014
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STAT	E, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			5 BASINGER MEMORIAL I DUNTAIN LAKE, MN 56			i du
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IE PRE TA	FIX	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD B	- 1	(X5) COMPLETION DATE
F 371	Continued From pa	*	F	371		6		
	window up and dow serving area) was c	used to pull the serving /n (which is directly over the coated with a thick layer of						1 - 1 <u>1</u> .1
	grease and dust in	e serving window also had the tract; f the stove was observed to	ha					· ·
	caked with dust and (6) Dried food and sides of the stove a (7) A greasy, dusty which held 3 food t		e					
•.	the initial kitchen to included: (1) In the walk in co	ems were also noted during ur on 2/24/14 at 9:10 a.m. a poler there was a package o n a plastic container. Intervi	f		- -			to da esta finanza esta esta esta esta esta esta esta esta esta
1000 - 100 1000 - 100 1000 - 100	to be thrown after 7 ham should have b in the refrigerator 1 (2) 3 containers of	e (DA)-A stated that food wa days of opening and that the een discarded as it had bee 8 days; thawed whipped topping that o open date identified on the	n at					
	 (3) uncovered slice the walk-in cooler; should not have be and not dated; (4) 6 cups of puddi cooler, uncovered a (5) a pack of turke manufacturers date 	es of pies located on plates i DA-A stated that the pie en in the walk-in uncovered ng located in the walk-in and undated; y breast lunch meat that had of 1/20/14 but not dated the DA-A did not know how						
FORM CMS-25	long it had been op (6) uncovered des	en. serts left in the walk-in coole n. during the observation of ervations.	the	Faci	lity ID: 00755	If continuatio	n sheet P	age 33 of 42

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/14/2014 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE COMI	E SURVEY PLETED
		245549	B. WING _			02/2	27/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEMO			
		· · · · · · · · · · · · · · · · · · ·		MOUNTAIN LAKE, M	N 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTIO CTIVE ACTION SHOULE NCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ae 33	F 37	71			
	(7) the refrigerator had 8 glasses of jui containers of half a and had a manufac	located near the serving area ce uncovered and 4 nd half that were not dated turers stamp of use by				·····	
	2 (a milk based sup	tainers of thawed Hormel Plus oplement) without dates to were removed from the					- 1044 - 10740 - 108-0091
	PLUS - 2 from the Conditions: KEEP F	mendation for the Hormel company is "Storage "ROZEN. Storage After Open: Life After Open: Up to 14 days "					
	4:50 p.m. cook- Av temperatures. The squash, tuna melt, sandwiches with sh Cook A retrieved ar from her pocket. Co of the 3 containers digital thermometer remove the food the located on the cour the digital thermom of the thermometer and then dropped t Cook -A removed the of tongs, wiped it w continued to check food items. It was n	meal on 2/26/14, beginning at vas observed to take food meal consisted of: beans, vegetable soup, Philly beef iredded cheese and crackers. Ind donned a pair of gloves bok-A tested the temperature of vegetable soup with a blue and then proceeded to ermometer from the dirty cup net, to verify the reading with eter. She wiped only a portion retrieved from the soiled cup he thermometer into the soup. ne thermometer with the use ith an alcohol wipe and the temperatures of the other noted her gloves were soiled emoved the soiled gloves and					
FORM CMS-2	retrieved another p p.m. At this time th instructed cook-A to responded, "why, I	air from her pocket at 5:00 le dietary manager (CDM) o wash her hands. Cook-A had gloves on?" but then and donned another pair of		Facility ID: 00755	If continuat	ion sheet l	Page 34 of 42
				•			5

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	MENT OF HEALTH						in a la sinta di si	FORM	03/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SU IDENTIFICATIC	PPLIER/CLIA	- · · · · · · · · · · · · · · · · · · ·		CONSTRUCTION	_		E SURVEY PLETED
		245	549	B. WING _		· · · · · · · · · · · · · · · · · · ·		02/2	27/2014
NAME OF F	PROVIDER OR SUPPLIER	4				REET ADDRESS, CITY, ST.			
GOOD S.	AMARITAN SOCIETY	- MOUNTAIN LA	KE			BASINGER MEMORIA DUNTAIN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG		(EACH CORRECTIN CROSS-REFERENCE		D BE	(X5) COMPLETION DATE
F 371	Continued From pa gloves from her po		·	F 37	71			1	
	The meal service s following was noted to have disposable reached out and ha which included the oven mitts on, takin sorting through res same soiled gloves buns out of the pac individual cheese s and placed individu plates.	d: Cook-A, who gloves on both andled contamin outside of the st ing food out of the ident menu slips a, Cook- A retrieve kage for sandwi lices to place or	was observed hands, ated surfaces eamer, putting e oven and b. With the ved individual iches, handled a sandwiches						
	At 5:10 Cook-A was serve individual pla picking up individual crackers with there observed to open of kitchen drawers an microwave, with the Cook-A was also o of bread out of a pl the toaster, with the buttered the toast, her hand on her sh the meal, touching without changing h	tes of food for re gloved hands. O upboard doors, d open the refrig e same soiled gl bserved to remo astic bag and pu e same soiled gl opened the over irt and then con buns, crackers	esidents, slices and Cook-A was steamer lid gerator and oved hands. ove two pieces ut the slices in oves. She n door, wiped tinued to serve						
	At 5:20 p.m., Cook serve individual boy When questioned i should be served, s During interview wi p.m. she verified th located on the back that staff do not da	wls of the contar f the contamina she stated "why th the CDM on 2 at the boxes of < shelf of the ref	minated soup. ted soup not." 2/26/14, at 3:45 Plus 2 were rigerator and						
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Marshall

									ווסס		02/14/2014
DEPART	IMENT OF HEALTH	AND HUMA	N SERVICES		· · · ·						03/14/2014 APPROVED
CENTER	RS FOR MEDICARE	& MEDICA	ID SERVICES				1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -		OMI	<u>B NO.</u>	0938-0391
	OF DEFICIENCIES		R/SUPPLIER/CLIA CATION NUMBER:			ONSTRUCTIO		•	(X		E SURVEY PLETED
		· ·	245549	B. WING _				-		02/2	27/2014
NAME OF I	PROVIDER OR SUPPLIER	•			STRE	ET ADDRESS,	, CITY, STA	TE, ZIP CO	DE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN	LAKE			BASINGER M					
(X4) ID PREFIX TAG	SUMMARÝ STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG				ACTION S	HOULD BI		(X5) COMPLETION DATE
F 371	Continued From pa	ade 35		F 3	71 、			×			
	from the freezer so	-	o system to	1.0	/ 1				a a sanaka		
1	monitor the length of										
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	were left in the refri										
	verified the milk-ba										· · · · · ·
	dated when remove								-		
	and placed into the	reingerator									1
	During another inte	rview with th	ne CDM on								
	2/27/14, at 8:45 a.n	n. she verifi	ed staff need to								VED to to Arcen
	change gloves betv										
	soup should not ha										
	have been removed the soiled thermom										
	the food item. She										11. Ref 14 g
	thermometers shou										
	soiled cup, should r										
	food temperatures. rationale for using t										
	verified that staff w										
	tongs to serve crac										· · ·
	instead of their han	ids.									· · ·
	Lines further review	u of the distu	andition of the								
	Upon further review kitchen, the CDM v										
	and grease, dirty ca				-						
	steamer, soiled cha			4							
	(which she stated s			1							1
	had never been cle		,	1	4						
	CDM confirmed she schedule. When the				i						
	regarding the clean			1							
	"what cleaning sche	edule?" Upo	n discovery of the								
	cleaning schedule i										1 17
	been documented a just going to start th										
	juor going to start i	ist concould	•	de la de							
	The facility Policy & Gloves revised Mar "Gloves are to be c	rch 2009, in:	structs that								
FORM CMS-2	567(02-99) Previous Versions	Obsolete	Event ID: EVOZ1	1	Facility	ID: 00755		If co	ontinuation	sheet	Page 36 of 42

		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 03/14/2014 FORM APPROVED MB NO: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245549	B. WING	·	02/27/2014
NAME OF F	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP CODE	
				745 BASINGER MEMORIAL DRIVE	
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		MOUNTAIN LAKE, MN 56159	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 371	contact with someth as opening a trash	ge 36 eat" foods. b. When coming in hing that is contaminated such can or touching a door knob or ezing, coughing or touching	F 37	1	
F 428 SS=D	the face or hair. d. / body fluids. "	After coming in contact with	F 42	Ativan had not been administer	ed
	reviewed at least or pharmacist.	of each resident must be nce a month by a licensed		since January and the resident longer required it, so the medica was discontinued by the physici The physician for Res 46 was	ation
	the attending physic	st report any irregularities to cian, and the director of reports must be acted upon.		contacted regarding the need to evaluate the continued use of Prozac or do a dose reduction a his response was documented. The Consulting Pharmacist was on 3/13/14 and performed an al facility review and the physician	and shere ll is
	by: Based on interview facility failed to ensu identified irregulariti indications and/or ir failed to ensure stat recommendations, R48) whose medica Findings include:	NT is not met as evidenced and document review, the use the consultant pharmacist es related to lack of clinical nadequate monitoring, and ff acted on pharmacy for 2 of 5 residents (R23 and ations were reviewed.		were notified of all recommendations contained in the report. The professional nursing staff were educated on 3/6/14 on the need review and notify the physicians all recommendations. The Dire of Nursing or her designee will a the monthly Consulting Pharmatic report for actions and follow thre for the next 3 months. Audit res will be presented at the monthly Quality Accuracy Committee	d to s of actor audit acist ough sults
	diagnosis from the form dated 12/10/1 dementia, Parkinso	eviewed. R23's active Minimum Data Set (MDS) 3, included hypertension, n's, anxiety and depression. A fental Status (BIMS)		Quality Assurance Committee meetings and any further action necessary will be determined by interdisciplinary team. Completion Date: 3/20/2014	

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STATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION). 0938-0391 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		3	co	MPLETED
		245549	B. WING		- 02	/27/2014
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STA		
GOOD S	AMARITAN SOCIETY	′ - MOUNTAIN LAKE		745 BASINGER MEMORIAL MOUNTAIN LAKE, MN 5		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 428	Continued From pa	-	F 42	8	an shawara na shin wasa na gara sa shin wasan sa sa s	
	scored 15/15 and	12/10/13, indicated R23 had was cognitively intact. Current idicated Ativan 0.5 milligrams				1921) 1932
	(mg) had been pre	scribed for anxiety or agitation ary (PRN) up to two times per				
	day.					
1997) 1997) 1997) 1997) 1997) 1997) 1997)	administration reco received Ativan 0.5 following times:	cember 2013 medication ord (MAR) indicated R23 had 5 mg for anxiety during the 6:30 p.m. given for agitation				Definition (1997) - Defini
	"calm/resting" at 7 (2) On 12/11/14, a discomfort and the	t 2:35 p.m. for general response to the medication				
· · · · · · · · · · · · · · · · · · ·	(3) On 12/16/13, a indication/reason f upon R23 after ad	or administration nor effect ministration of the medication;				
	indication/rationale medication;	at 3:00 p.m. with no nor results from receiving the				· • • •
	rationale for use w (6) On 12/27/13, a "c/o (complaints of	t 9:30 p.m. with no indication or ith no results documented; at 2:10 p.m. Ativan given for) general pain/restless'' with king to indicate the response to d				
	(7) On 12/30/13, a administered for a					
	Ativan 0.5 mg had dates:	nuary 2014 MAR indicated been given on the following				
		5:30 p.m. administered without se nor documented resident				

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		& MEDICAID SERVICES				0938-0391 E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION		PLETED
		245549	B. WING		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		1. 1. 1.
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEMORIAL DI MOUNTAIN LAKE, MN 561		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 428	Continued From pa	ge 38	F 4	28		· · · ·
	(2) On 1/9/14, at 7: anxiety without doc anxiety symptoms	30 p.m. administered for umentation describing the nor whether the resident			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
		edication. s lacking in the record for R23 at side effect monitoring for the				
	Monthly Drug Revie conducted and the Problems" on 12/12 indicating no drug p	umentation on the form titled, ew Documentation was pharmacist had recorded "No 2/13, 1/13/14 and 2/12/14, problems had been identified				in line for the Alexi Constant of Alexi Constant of Alexies Constant of Alexies
	pharmacist. During pharmacist on 2/27 pharmacist verified been addressed in	vas signed by the consultant interview with the consultant /14, at 8:40 a.m., the R23's use of Ativan had not the pharmacy reviews for anuary 2014 or February				
	2/27/14, at 9:30 a.r been no recommer regarding R23's int Ativan without adeo	th the director of nursing on n., the DON verified there had ndations from the pharmacist ermittent use of the medication quate indications for use and/or nedication's effectiveness.				
	indicated the reside 5/3/11 with diagnos physician orders in	eviewed and the face sheet ent had been admitted on ses including depression. The dicated R46 had been c 10 mg (milligrams) po (by 5/13.				
	form from the cons	avior-Medication monitoring ulting pharmacist, dated 'Six month drug re-evaluation				··· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ·· ··

MAR 2 7 2014

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		245549	B. WING		02/27/2014
NAME OF F	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		45 BASINGER MEMORIAL DRIVE IOUNTAIN LAKE, MN 56159	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE COMPLÉTION
F 428	dose response obs depressive/dement reduction if no long	10 mg daily. Please document erved for controlling target ia symptoms or attempt dose er needed". The form lacked esponse from either the	F 428		
F 465	director of nursing (had not attempted a as why R46 should Prozac since startin The DON confirme monitoring form dat	2/27/14, at 1:45 p.m. the (DON) confirmed the physician a GDR or provided rationale continue on the medication ng the medication on 2/25/14. d the Behavior-Medication ted 8/10/13 from the been communicated to the v of the pharmacy	F 465		
SS=C	E ENVIRON The facility must pr	AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for			
	This REQUIREMEN by: Based on observat review the facility fa in 4 of 4 resident ha wings) in a safe and to replace stained of hallways (200 and 4	NT is not met as evidenced tion, interview and document ailed to maintain the floor tiles allways (100, 200, 300 and 400 d sanitary manner; and failed ceiling tiles in 2 of 4 resident			
:	Findings include:	nental tour with the		· · ·	

MAR 2 7 2014.

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL		E CONSTRUCTION		0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				PLETED
		245549	B. WING			02/	27/2014
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE			45 BASINGER MEMORIAL DRIVE		() () () () () () () () () ()
	· · · · · · · · · · · · · · · · · · ·			M	IOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
		40					
F 465	Continued From pa	 A specific terms of the second se second second sec	F 4	65	F465 FUNCTIONAL SANITAR	vienie () V	a marandar da sa a canad
		lirector of environmental			COMFORTABLE ENVIRONME		
	following observation	2:00 p.m. on 2/27/14, the			The facility has custodial proce		
	Tonowing observation	bis were made.			in place for care of floors and	uures	
	There were areas t	he length of the resident			ceilings. In the past 2 years ne	۸۸/	
		to be stained and to have a			flooring, Teknoflor in all resider		
		e floor tiles were observed to		ļ	room, bathrooms, resident dini		
		white tiles. Numerous floor tiles			rooms and dining corridor; Cera		(1893) 2. (1993) (1993)
·		hallways had become			Daltile in resident tub and show		- 11-03
		sh, charcoal and/or black in			rooms, and public rest rooms; r		
		ed areas were noted to be os throughout the halls.			Shaw carpeting in the sunroom		
	present in long sur	bs throughout the nails.			family dining room, therapy roo	-	
· ·	The 100 wing, 200	wing and 300 wing floors			chapel, and administrative offic		
1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -		ing the environmental tour to			wing and entry. New floor tile h		
		acked tiles the width of the			been ordered and installed in the		
-	hallways. At the en				four corridor wings identified whether	nere	
		rd of the way down the hallway			some settling and cracking has		
		that spread across 5 floor tiles. he 400 wing, one section of			occurred. All four corridors will		· .
		observed. The administrator	;		wings have been stripped and		
	4	our that the cracks could be			rewaxed. The four stained ceil	ing	
· .		ettling/shifting or just normal			tiles have been replaced as we	11.	•
	wear and tear.				Floors and ceilings will be routi	nely	-
				1	checked by Maintenance and		
		wn the 200 and 400 wings		ĺ	cleaned, waxed or replaced as		
		ave numerous large stained ne of the tiles appeared			needed. This will be monitored		
		an/gray color and others had a			the Environmental Services Dir		
		on. The administrator verified			and/ or his designee and result		
		ceiling tiles should be			reported at the monthly Quality		·
	changed.				Assurance Committee meeting		1 1 1
					Any further action, if needed wi		
		on 2/27/14, at 2:30 p.m. the			determined by the interdisciplin	ary	. ÷
		DES were not sure of the			team.		21
		lored areas on the floor tiles. onnel, (FCP)-B was		1	Completion Date: 3/20/2014		2/20/1
		same time and described the				· · · · · · · ·	Ialle
		the floors. FCP-B said the					

TATEMENT		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
IND PLAN O	FCORRECTION	A. BUILDING		COM	PLETED	
		245549	B. WING		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		· .
GOOD S	AMARITAN SOCIETY	(- MOUNTAIN LAKE		745 BASINGER MEMORIAL D MOUNTAIN LAKE, MN 561		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 465	Continued From pa	202 11	F 4	65		
:	floors were waxed provide care to res	in "strips" so staff could idents who lived down the		00	an an an ann	n an
	strip of the original fresh wax. FCP-B	er stated staff did not routinely wax prior to application of a said the staff utilized a new PForward" which did not				
	remove the old wa	x very well. The DES verified p had not been stripped from				
•••••						t taraf
						د ب بر
-						
						10日 11日
: : :						a na artana

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TATEMEN	IT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DA	D. 0938-03 TE SURVEY MPLETED
		245549	B. WING		0	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/25/2014
GOOD S	SAMARITAN SOCIETY			745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETI DATE
K 000	INITIAL COMMEN	TS	K 00	0		1
	FIRE SAFETY					
8-14	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE ATION OF COMPLIANCE.		Docth 3 3-31-14		
-k ie	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.		ť		
8-27-14 De	Minnesota Departm Fire Marshal Divisio the time of this surv Samaritan Society I to be in substantial requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association fety Code (LSC), Chapter 19		RECEIVED MAR 2 8 2014]	A RELEVANT REPORT OF A RELEVANT REPORT A RELEVANT RE
東京	DEFICIENCIES (K- Health Care Fire Ins State Fire Marshal I 445 Minnesota Stre St. Paul, MN 55101-	R THE FIRE SAFETY TAGS) TO: spections Division et, Suite 145 -5145, or		MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION]	
		ER/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		(X6) DATE
In	in Swalter	2		Administration	2	125/14

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.

Q.

RE & MEDICAID SERVICES			O,		PPROV
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
245549	B. WING _			02/2	5/2014
ER		STREET ADDRESS, C	TY, STATE, ZIP CODE	02/2	0/2014
TY - MOUNTAIN LAKE					
STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORI	RECTIVE ACTION SHOULD	BE	(X5) COMPLETH DATE
page 1	K 00	0			
)state.mn.us					78
ORRECTION FOR EACH JST INCLUDE ALL OF THE FORMATION:		*		ž	
f what has been, or will be, done iciency.				:	
proposed, completion date.					
/or title of the person prrection and monitoring to rence of the deficiency.					
od Samaritan Society Mountain Icted as follows:					
basement, is fully fire sprinkler s determined to be of Type					
addition is one-story, has no fire sprinkler protected and was of Type II(000) construction;					
fire sprinkler protected and was : of Type II(000) construction.					
fire alarm system with smoke prridors and spaces open to the 1 monitored for automatic fire ation. The facility has a Is and had a census of 53 at					
at 42 CFR, Subpart 483.70(a) is enced by:					
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549 TY - MOUNTAIN LAKE STATEMENT OF DEFICIENCIES RCY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION) page 1 2 state.mn.us ORRECTION FOR EACH JST INCLUDE ALL OF THE FORMATION: f what has been, or will be, done iciency. proposed, completion date. //or title of the person prection and monitoring to trence of the deficiency. od Samaritan Society Mountain cted as follows: ing was constructed in 1976, is basement, is fully fire sprinkler s determined to be of Type on; addition is one-story, has no fire sprinkler protected and was of Type II(000) construction; addition is one-story, has no fire sprinkler protected and was of Type II(000) construction. fire alarm system with smoke pridors and spaces open to the monitored for automatic fire ation. The facility has a ls and had a census of 53 at	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A BUILDIN 245549 ER IY - MOUNTAIN LAKE STATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ID PREFIX TAG page 1 K 00 Questate.mn.us ORRECTION FOR EACH JST INCLUDE ALL OF THE FORMATION: f what has been, or will be, done iciency. f what has been, or will be, done iciency. proposed, completion date. //or title of the person prection and monitoring to rence of the deficiency. od Samaritan Society Mountain cted as follows: ing was constructed in 1976, is basement, is fully fire sprinkler s determined to be of Type on; addition is one-story, has no fire sprinkler protected and was of Type II(000) construction; addition is one-story, has no fire sprinkler protected and was of Type II(000) construction. fire alarm system with smoke prridors and spaces open to the monitored for automatic fire ation. The facility has a is and had a census of 53 at	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDIN B. WING 245549 B. WING FR STREET ADDRESS, CI 745 BASINGER MEN MOUNTAIN LAKE STATEMENT OF DEFICIENCIES CCY MUST BE PRECEDED BY FULL RUSCIDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER (EACH CORE (EACH C	(*1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 B. WING 245549 B. WING SR STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE STATEMENT OF DEFICIENCIES COMUNTS BE PRECEDED BY FULL SIS DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER/S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLL) OROSS-REFERENCED TO THE FORMATION: page 1 K 000 @state.mn.us ORRECTION FOR EACH STY INCLIDE ALL OF THE FORMATION: f what has been, or will be, done iciency. FOR OPERATION date. for title of the person precision and monitoring to rence of the deficiency. For the person on; raddition is one-story, has no fire sprinkler s determined to be of Type on; raddition is one-story, has no fire sprinkler protected and was of Type II(000) construction; raddition is one-story, has no fire alarm system with smoke printors and spaces open to the monitored for automatic fire ation. The facility has a Is and had a census of 53 at	RE & MEDICAID SERVICES OMB NO. ((X1) PROVIDENUEWULER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 (X3) OATE COMP 245549 B. WING 02/2 STATEMENT OF DEFICIENCIES INCOMINTAIN LAKE STREET ADDRESS, CITY, STATE, ZIP CODE TATEMENT OF DEFICIENCIES INCOMINT BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION) DEFOURCEY SUPLAND OF CORRECTION NOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) page 1 K 000 QState.mn.us ORRECTION FOR EACH STITIENT OF THE FORMATION: ORRECTION FOR EACH STITIENT OF THE STITIENT OF THE FORMATION: DEFICIENCY) page 1 K 000 QState.mn.us ORRECTION FOR EACH STITIENT OF THE FORMATION: ft what has been, or will be, done iciency. DEFICIENCY) proposed, completion date. Vor title of the person Treate of the deficiency. od Samaritan Society Mountain cted as follows: mg was constructed in 1976, is basement, is fully fire sprinkler stadition is one-story, has no fire sprinkler protected and was of Type II(000) construction, raddition is one-story, has no fire sprinkler protected and was of Type II(000) construction. fire am system with smoke irridors and spaces open to the monitored for automatic fire ation. The facility has a is and had a census of 53 at

		AND HUMAN SERVICES			F	ORM /	03/14/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE	E SURVEY PLETED
		245549	B. WING _			02/2	25/2014
	(EACH DEFICIENC)	- MOUNTAIN LAKE TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	74 MC	REET ADDRESS, CITY, STATE, ZIP CODE 5 BASINGER MEMORIAL DRIVE DUNTAIN LAKE, MN 56159 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 018 SS=D	Doors protecting or required enclosures hazardous areas a those constructed of wood, or capable o minutes. Doors in required to resist th no impediment to the are provided with a the door closed. D are permitted.	FETY CODE STANDARD prridor openings in other than s of vertical openings, exits, or re substantial doors, such as of 1 ³ ⁄4 inch solid-bonded core f resisting fire for at least 20 sprinklered buildings are only the passage of smoke. There is ne closing of the doors. Doors means suitable for keeping utch doors meeting 19.3.6.3.6 0.3.6.3 prohibited by CMS regulations cilities.	K 01	8	K 018 DOOR OPENINGS The manual flush bolt on the inaction door leaf of the linen storage room has been replaced with automatic spring latches to assure the door are positively latching when close Ongoing compliance will be monitored by the Director of Environmental Services and/or his designee. Results will be presen at the monthly Quality Assurance Committee meetings and any fun- action, if necessary will be determined by the interdisciplinant team. Completion Date: 3/27/14	m c rs ed. is nted e ther	3/27//14
	Based on observat located on the 400 positively latch into practice was not in requirements at NF Section 19.3.6.3. In deficient practice co residents, staff and FINDINGS INCLUD On 02/25/2014 at 1 ^o a set of side-hinged			which have not a real of the second			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00755

If continuation sheet Page 3 of 5

	F OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	OMB NO	E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	1.	ING 01 - MAIN BUILDING 01		IPLETED
	and the second	245549	B. WING		02/	25/2014
NAME OF	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOOD S	AMARITAN SOCIET	Y - MOUNTAIN LAKE		745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
K 018	Continued From p	age 3	K 0'	18		
	When closed, thes	e doors did not positively latch, h bolts on the inactive door leaf				
	engineer at the tim	onfirmed with the chief building le of discovery. AFETY CODE STANDARD	K 05	52		
SS=F	installed, tested, a with NFPA 70 Natio 72. The system ha	n required for life safety is nd maintained in accordance onal Electrical Code and NFPA is an approved maintenance im complying with applicable FPA 70 and 72. 9.6.1.4		K 052 FIRE ALARM MAINTENANCE The proper documentatior at the time of the survey w subsequently received fro	las	
		is not met as evidenced by: ew of available documentation.		alarm monitoring vendor w routinely performs the ann alarm inspection and test. document has been added files. The Director of Envi Services and/or his design monitor that proper docum received annually as requi will verify that it includes in	ual fire This d to the ronmental nee will nentation is ired and dentifying	
	the facility failed to alarm system in ac Chapter 9, Section 19.3.4.1, and NFPA 7-3.2 and 7-5.2.2 a emergency, this de	maintain the building fire cordance with NFPA 101 (00) 9.6 and Chapter 19, Section A 72 (1999 edition) Sections nd, Table 7-3.1. In a fire ficient practice could adversely dents, staff and visitors.		the location and outcome visual and functional test r each alarm initiating devic of this monitoring will be p at the monthly Quality Ass Committee meeting for rev any further action, if neces be determined by the interdisciplinary team.	esults of e. Results resented urance view and	
	the facility's annual	0:30 AM, during a review of fire alarm inspection & test 2014, eleven (11) manual fire		Completion Date: 3/3/2014	1	3/3/16

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00755

If continuation sheet Page 4 of 5

	HEALTH AND HUMAN EDICARE & MEDICAID						D: 03/1 MAPPR O: 0938	ROVED
STATEMENT OF DEFICIENC	CIES (X1) PROVIDER/		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SU COMPLE		/EY
	24	45549	B. WING			0	2/25/20	14
NAME OF PROVIDER OR	SUPPLIER SOCIETY - MOUNTAIN L	_AKE		745 BASINGE	ESS, CITY, STATE, ZIP (R MEMORIAL DRIVE LAKE, MN 56159	CODE		
PREFIX (EACH [MMARY STATEMENT OF DEFI DEFICIENCY MUST BE PRECE TORY OR LSC IDENTIFYING I	EDED BY FULL	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CO H CORRECTIVE ACTION -REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMF	X5) PLETION ATE
detectors of documenta locations a functional Initiating D verified that device on properly co	es and thirty-seven (37 were noted on the syste ation was provided ider and outcomes for both test results for each of revices. As such, it cou at visual and functional the fire alarm system h	em, however, no ntifying the visual and these Alarm uld not be testing of each ad been	K 05	2				
				 A set exceeded at the set of th				
ORM CMS-2567(02-99) Previo	ous Versions Obsolete	Event ID: EVOZ2	1 F	acility ID: 00755		If continuation s	heet Page	a 5 of

TATEMEN	T OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP		OMB NO. (X3) DATE	SURVEY
ND PLAN (OF CORRECTION		A. BUILDING	02 - 2013 LINK ADDITION	COMPLETED	
			B. WING		02/2	5/2014
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE		
GOOD S	AMARITAN SOCIET	Y - MOUNTAIN LAKE		MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETI DATE
K 000	INITIAL COMMEN	NTS	K 000			
	FIRE SAFETY					
	ALLEGATION OF DEPARTMENT'S SIGNATURE AT T PAGE OF THE CI	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR THE BOTTOM OF THE FIRST WS-2567 FORM WILL BE CATION OF COMPLIANCE.		Pocoh 31-14		
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE IAS BEEN ATTAINED IN WITH YOUR VERIFICATION.			<u>,</u> 	e Ř. S
	Minnesota Depart Fire Marshal Divis the time of this su Samaritan Society to be in substantia requirements for p Medicare/Medicaid 483.70(a), Life Sat edition of National	d at 42 CFR, Subpart fety from Fire, and the 2000 Fire Protection Association afety Code (LSC), Chapter 18		RECEIVED MAR 2 8 2014		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	OR THE FIRE SAFETY		MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION		
5	Health Care Fire Ir State Fire Marshal 445 Minnesota Str St. Paul, MN 5510	Division eet, Suite 145				
RATORY	DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGNAT	URE	TITLE	()	6) DATE
Im	- Swande			on may be excused from correcting providin	3	25/1

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.

		AND HUMAN SERVICES				FORM): 03/14/201 1 APPROVE 2. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - 2013 LINK ADDITION	(X3) DA	TE SURVEY MPLETED
		245549	B. WING			02	/25/2014
	PROVIDER OR SUPPLIER			745	EET ADDRESS, CITY, STATE, ZIP CODE BASINGER MEMORIAL DRIVE UNTAIN LAKE, MN 56159	1 02	12312014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	K 00	0			
	By eMail to: Marian.Whitney@s	state.mn.us					
		RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION:					
đ	1. A description of to correct the defici	what has been, or will be, done ency.	1				1
	2. The actual, or pr	oposed, completion date.					1
	3. The name and/o responsible for corr prevent a reoccurre	r title of the person rection and monitoring to ence of the deficiency.					
	Lake consists of the one-story in height, sprinkler protected, Type II (111) constr sleeping or treatme 02. Building 02 is s	d Samaritan Society Mountain e 2013 Link Addition. It is has no basement, is fully fire and was determined to be of uction. There are no resident nt areas located in Building eparated from an assisted oper two-hour fire wall		And Annual An			
	detection in the corr corridors which is m department notificat	e alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion. The facility has a and had a census of 53 at					
K 052 SS=F	NOT MET as evider	42 CFR, Subpart 483.70(a) is ' nced by: FETY CODE STANDARD	K 05	2			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00755

If continuation sheet Page 2 of 3

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG 02 - 2013 LINK ADDITION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
		245549	B. WING		02/25/2044
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	02/25/2014 E
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLET
K 052	installed, tested, and with NFPA 70 Nation 72. The system has	required for life safety is d maintained in accordance nal Electrical Code and NFPA an approved maintenance complying with applicable	K 05	K 052 FIRE ALARM MAINTENANCE The proper documentation r	missing
	Based upon a revie the facility failed to n alarm system in acc Chapter 9, Section 9 18.3.4.1, and NFPA 7-3.2 and 7-5.2.2 an emergency, this defi affect 55 of 55 reside	not met as evidenced by: w of available documentation, naintain the building fire ordance with NFPA 101 (00) 0.6 and Chapter 18, Section 72 (1999 edition) Sections d, Table 7-3.1. In a fire cient practice could adversely ents, staff and visitors.		at the time of the survey wa subsequently received from alarm monitoring vendor wh routinely performs the annua alarm inspection and test. T document has been added t files. The Director of Enviro Services and/or his designed monitor that proper document received annually as require will verify that it includes iden	s the o al fire This to the nmental e will ntation is od and
	the facility's annual fi report dated 02/11/20 alarm boxes and thir detectors were notec documentation was p locations and outcom functional test results Initiating Devices. As	:30 AM, during a review of ire alarm inspection & test 014, eleven (11) manual fire ty-seven (37) room smoke d on the system, however, no provided identifying the nes for both visual and s for each of these Alarm is such, it could not be ad functional testing of each		the location and outcome for visual and functional test res each alarm initiating device. of this monitoring will be pres at the monthly Quality Assur- Committee meeting for review any further action, if necessa be determined by the interdisciplinary team. Completion Date: 3/3/2014	both sults of Results sented ance w and
-	This finding was conf	irmed with the chief building			

If continuation sheet Page 3 of 3



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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,

Kumalu 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

Enclosure(s)

cc: Original - Facility Licensing and Certification File

PRINTED: 03/14/2014 FORM APPROVED

Minneso	ta Department of He	alth			-	_
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00755	B. WING		02/2	7/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		INGER MEMO IN LAKE, MN	ORIAL DRIVE V 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall I with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	On February 24nd, surveyors of this De above provider and orders are issued. completed, please s these orders and re	25nd, 26th and 27th, 2014, epartment's staff, visited the the following correction When corrections are sign and date, make a copy of eturn the original to the nent of Health, Division of		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

EVOZ11

DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			SURVEY LETED
	00755	B. WING		02/2	7/2014
	- MOUNTAIN LAK 745 BAS	INGER MEM	ORIAL DRIVE		
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLET DATE
ntinued From pa	ge 1	2 000			
rtification Progra	m, 1400 E. Lyon Street,		far left column entitled "ID I The state statute/rule numb corresponding text of the sta out of compliance is listed in "Summary Statement of De column and replaces the "To portion of the correction ord column also includes the f are in violation of the state s statement, "This Rule is not evidenced by." Following to findings are the Suggested Correction and the Time Pe Correction. PLEASE DISREGARD THE THE FOURTH COLUMN W STATES, "PROVIDER'S PL CORRECTION." THIS APP FEDERAL DEFICIENCIES WILL APPEAR ON EACH F THERE IS NO REQUIREM SUBMIT A PLAN OF CORF	Prefix Tag." er and the ate statute/rule n the ficiencies" o Comply" ler. This indings which statute after the the surveyors Method of riod For E HEADING OF (HICH AN OF LIES TO ONLY. THIS PAGE. ENT TO RECTION FOR	
	5 Subp. 3 Comprehensive	2 565			
ist be used by all	personnel involved in the				
is MN Requirem	ent is not met as evidenced				
	VIDER OR SUPPLIER ARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Intinued From pa impliance Monito intification Progra arshall, Minnesota A Rule 4658.0409 an of Care; Use bp. 3. Use. A co ist be used by all re of the resident	ARITAN SOCIETY - MOUNTAIN LAN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 1 Impliance Monitoring, Licensing and Irtification Program, 1400 E. Lyon Street, arshall, Minnesota 56258.	ORRECTION IDENTIFICATION NUMBER: A. BUILDING 00755 B. WING	DORRECTION DENTIFICATION NUMBER: A. BUILDING: 00755 B. WING //DER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE XRITAN SOCIETY - MOUNTAIN LAX 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYINS INFORMATION) PREFIX TAG PROVIDERS PLAN OF CO (CROSS-REFERENCIENCY) Initiated From page 1 2 000 The assigned tag number a far left column entitled "ID I The state statute/rule numb corresponding text of the state out of compliance is listed in "Summary Statement of De column also includes the fare in violation of the state out of compliance is listed in "Summary Statement of De column also includes the fare in violation of the state statement, "This Rule is no evidenced by." Following t findings are the Suggested Correction and the Time Pe Correction. PLEASE DISREGARD THE THE FOURTH COLUMN N STATES, "PROVIDERS PROVIDERS WILL APPEAR ON EACH F THERE IS NO REQUIREM SUBMIT A PLAN OF CORP VIOLATIONS OF MINNES STATUTES/RULES. N Rule 4658.0405 Subp. 3 Comprehensive an of Care; Use 2 565 bp. 3. Use. A comprehensive plan of care is to used by all personnel involved in the re of the resident. 2 565	JORRECTION IDENTIFICATION NUMBER: A BUILDING: COMP 00755 B. WING 02/2 ADER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAK 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG COMPONENT CONTRACT ACTION (EACH DEFICIENCY BASING ACTION) ID PREFX TAG COMPONENT CONTRACT CORRECTION ID PREFX TAG COMPONENT CONTRACT CORRECTION TO CONTRACT ACTION SUBMIT AD LAN OF COMPLY DOTION OF the State statutor/ule and the corresponding text of the state statutor/ule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the findings which are in violation of the state statutor/ule SUBMIT APLAN OF CORRECTION. THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. <td< td=""></td<>

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED
		00755	B. WING		02/	27/2014
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		INGER MEMO NN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 565	review, the facility f as defined in the pl (R4) reviewed who oral hygiene. Findings include: R4's medical record dated 2/26/14, indic care deficit related mobility, and interve total assist with oral In addition, review f indicated R4 had a included multiple se quarterly Minimum 11/27/13, identified for Mental Status (I indicating intact cog identified R4 as new with grooming. During observation was noted that R4 bottom teeth appear stated during interv not brush her teeth her teeth maybe or reported that staff f previous evening o During observation lower teeth had wh	ion, interview and document ailed to provide oral hygiene an of care for 1 of 3 residents were dependent upon staff for d was reviewed. The care plan cated R4 had a problem of self to weakness and limited entions included the need for l care twice daily. of the face sheet in the record dmission diagnoses which clerosis and neuropathy. The Data Set (MDS) dated d that R4 had a Brief Interview BIMS) score of 15/15, gnition. The MDS also eding total assist from staff on 2/25/14, at 11:06 a.m. it had no upper teeth and the ared dirty with debris. R4 riew at that time that staff do daily. R4 said the staff brush nce a week and further had not brushed her teeth the r that morning during cares. on 2/26/14, at 1:48 p.m. R4's at appeared to be a build-up or stated her teeth had not been			т)	
	During interview wi	th R4 on 2/27/14 at 9:00 a.m.,				

Minnesc	ta Department of He	ealth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU				(X3) DATE COMP	SURVEY LETED
		00755		B. WING		02/2	7/2014
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAP		NGER MEMO IN LAKE, MN	ORIAL DRIVE V 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 3		2 565			
2 565	R4 stated her teeth evening during care good one" and that cares were provide might brush them co other staff). During interview wit a.m., NA-A stated s when cares are pro- she doesn't work w During interview wit 2/27/14, at 8:53 a.m expected to provide and evening cares. cognitively intact ar whether or not staff defined on the plan During interview wit (DON) on 2/27/14, expectation was that resident's care plan the morning and the verified that R4 was be accurate in repo- been provided. SUGGESTED MET The director of nurs to follow care plans cares and services to audit and monito	were not brushed th es. R4 stated NA-A w she brushed her tee d. R4 again stated, ' once a week" (referer th NA-A on 2/27/14, a she always brushes F ovided. However, NA ith R4 that often. th registered nurse (F n., RN-A verified the e oral cares during m RN-A confirmed that ad could accurately re- f had brushed her tee of care. th the director of nurse at 10:05 a.m. she stat at staff would follow the and provide oral care e evening. The DON is cognitively intact an orting whether oral care in regards to specifi , and could develop a	vas "a th when 'they noce to at 9:30 R4's teeth -A stated RN)-A on NAs were orning at R4 was eport eth as sing ated the he re both in also nd would res had FION: e all staff c resident a system				
	(21) days.		.,				
Minnocata D	epartment of Health						
vinnesota D	evanment of Healm						

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		INGER MEMO AIN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 855	Continued From pa	age 4	2 855			
2 855	MN Rule 4658.0520 Proper Nursing Ca	0 Subp. 2 E. Adequate and re;Oral Hygiene	2 855			
	proper care. The c adequate and prop E. Assistance as n keep the mouth, tec	or determining adequate and criteria for determining er care include: needed with oral hygiene to eth, or dentures clean. used to prevent dry, cracked				
	by: Based on observati review the facility fa maintain oral hygie	ent is not met as evidenced ion, interview and document ailed to provide services to ne for 1 of 3 residents (R4) dependent upon staff for oral				
	Findings include:					
	sheet indicated R4	d was reviewed. The face had admission diagnoses tiple sclerosis and neuropathy				
	11/27/13, identified for Mental Status (E indicating intact cog identified R4 as new with grooming. The indicated R4 had a related to weaknes	num Data Set (MDS) dated d that R4 had a Brief Interview BIMS) score of 15/15, gnition. The MDS also eding total assist from staff e care plan dated 2/26/14, problem of self care deficit s and limited mobility, and the led the need for total assist e daily.				
	was noted that R4 bottom teeth appea	on 2/25/14, at 11:06 a.m. it had no upper teeth and the ared dirty with debris. R4 riew at that time that staff do				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/27/2014	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		INGER MEMO NN LAKE, MN			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
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2 855	Continued From pa	ige 5	2 855			
	her teeth maybe or reported that staff h	daily. R4 said the staff brush ace a week and further had not brushed her teeth the r that morning during cares.				
	lower teeth had what	on 2/26/14, at 1:48 p.m. R4's at appeared to be a build-up of stated her teeth had not been or this morning."	F			
	nursing assistant (N	on 2/27/14 at 8:16 a.m., NA)- A was observed providing R4. NA-A was observed to				
	9:00 a.m., R4 state the prior evening du was "a good one" a when cares were p	terview with R4 on 2/27/14 at d her teeth were not brushed uring cares. R4 stated NA-A and that she brushed her teeth rovided. R4 again stated, hem once a week" (reference				
	a.m., NA-A stated s	th NA-A on 2/27/14, at 9:30 she always brushes R4's teeth wided. However, NA-A stated ith R4 that often.				
	2/27/14, at 8:53 a.n expected to provide and evening cares. cognitively intact an	th registered nurse (RN)-A on n., RN-A verified the NAs were e oral cares during morning RN-A confirmed that R4 was nd could accurately report f had brushed her teeth as of care.				
	(DON) on 2/27/14, expectation was the	th the director of nursing at 10:05 a.m. she stated the at staff would follow the and provide oral care both in				

Minneso	ta Department of He	alth			FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/2	27/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NGER MEMO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETE DATE
2 855	Continued From pa	ge 6	2 855			
	verified that R4 was	e evening. The DON also cognitively intact and would rting whether oral cares had				
	The director of nurs could review policy regarding providing requiring physical a The Quality Assess	HOD FOR CORRECTION: sing (DON) and/or designee and provide education for staff oral hygiene to residents ssistance with tooth brushing. ment and Assurance (QAA) orandom audits to ensure				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 960	MN Rule 4658.0600 Food Quality) Subp. 1 Dietary Service -	2 960			
		uality. Food must have taste, ance that encourages resident d.				
	by: Based on observati failed to provide me attractive for 7 of 52	ent is not met as evidenced on and interview the facility eals that are palatable and 2 residents (R10, R13, R33, 65) who were served meals.				
	Findings include:					
	expressed dissatisf the facility stating, " good and sometime	2/25/14, at 10:14 a.m. R10 action with the food served at It's edible; sometimes it's very es it's very poor". During ation/interview on 2/27/14, at				

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00755	B. WING			
IAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NGER MEMOI IN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 960	11:45 a.m. R10 stat served for supper of good". R10 further melt sandwich that Documentation on the Status (BIMS), date cognitively intact and When questioned at 5:39 p.m., R13 was she had been eatin what this is, I really R13 had a BIMS so which indicated cog During interview on stated the food serve R31 awaited her met tablemate's (R51) so mine's not like that" melt sandwich was black in color and at that one day when the supposed to be me instead, "and they we stated she had bee had so much pepper burnt my throat goin During a subsequent 11:45 a.m. R31 stat finally served the ni tomato soup which department, stating R31 was offered mid declined and then so soup and that was '	ted the tomato soup she was in 2/26/14 was "not very stated she sent back the tuna was served as it was burnt. the Brief Interview for Mental ed 2/13/15 indicated R10 was id had a score of 15/15. About the meal on 2/25/14 at is unable to identify the meat g and stated, "I don't know don't, it is so dry."				

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00755	B. WING		02/	02/27/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		INGER MEMO IN LAKE, MN				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 960	Continued From pa	age 8	2 960				
	stated, "The food is R33 further stated to the quality of the food food being too cold indicated that about were served meath been "taken off of so were people who ut food that were com further stated, "The R33 confirmed the and stated although sprig of green on the plate to appearance. R33 food 15/15 which indice During and interviee expressed dissatist stating, "The food is have it heated up we they serve that bare of improvement in to whether the food ta question I wish you make stuff that tast supposed to have re balls and they were shot. The food is of During an observat following day on 2/2 "The food is always couple weeks ago to meatloaf so I thoug ordered it. I got me	had a BIMS score on 1/22/14 cated cognitive intact. w on 2/25/14 at 9:40 a.m. R45 faction with the food served s usually too cold. I ask to when we have soup because ely warm. There could be a lot the kitchen." When asked usted good he stated, "That is a had not asked. They don't tes good. They were meatloaf but they served meat a hard enough to use for a sling					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00755	B. WING		02/	02/27/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
GOOD SA	AMARITAN SOCIETY		INGER MEMOI NN LAKE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 960	Continued From pa	ige 9	2 960				
	on 12/4/13 of 15/15 which indicated he was cognitively intact.						
	expressed dissatisf stating, "Today at lu the chicken breast green bean casserd give you your yogu omelet on a cold pl right temperature. working on it but it of During an observat 2/26/14, at 5:50 p.m her table to make m melt which was bla "And I am expected manager was ques in question, she ver	ion of the supper meal on n. R53 called the surveyor to note of the open faced tuna ck on the bottom. She stated d to eat that"? After the dietary tioned regarding the tuna melt rified the sandwich should not and proceeded to find an	,				
	station and stated t sandwich had been offered me a grilled but at that point I ha thought what the he they brought me the was black and the o questioned whethe she was sick of it a it. R53 had a BIMS which indicated sh	a.m. R53 entered the nursing hat after the burnt tuna returned to the kitchen, "They cheese which I don't care for ad been waiting an hour and I eck, I'll take anything. Then e grilled cheese and the top cheese wasn't melted!" When r an alternative was offered, nd just took the top off and ate score on 12/25/13 of 15/15 e was cognitively intact.	/				
	stated, "The food is comes out of a truc	on 2/25/14, at 10:09 a.m. R65 s very poor quality because it k, there are very few home The only good meat is the roas	t				

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/27/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		INGER MEMO IN LAKE, MN			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 960	Continued From pa	age 10	2 960			
	out. If the meat is c vegetables are too Just watch the mea see what I mean. V one listens to us." Later, during the no p.m. R65 was serve R65 stated, "Look a overcooked and the was observed durin that R65 was serve vegetables with bro again, overcooked sit there before we the problem with th what you can do ab	erything is very tough and dried chicken, it is dried out, and the overcooked with little flavor. als in the dining room, you will Ve keep complaining but no oon meal on 2/25/14, at 12:30 ed broccoli and ham for lunch. at this broccoli, it is e ham is tough and dry." It ng the noon meal on 2/26/14, ed pork roast and mixed occoli. R65 stated, "Here it is and dried out, how long does it get it? That has to be part of e overcooking, Please see bout the food here." R65's 5/15, which indicated he was				
	dietary manager (D served the prior eve	2/27/14, at 1:11 p.m. the M) confirmed the tuna melts ening (2//26/14) were dicated the cook "should have				
	obtained and tested was served by cool immediately after th served to the last re of: beef with gravy baked potato, mixe meat (beef) and gra noted to taste very dry, straw-like and was lukewarm and	5 p.m. a test tray was d by two surveyors. The food k -A. The food was dished he last plate was dished and esident. The menu consisted , ham, mashed potatoes, d vegetables, carrots, ground bund ham. The ham was dry and the ground ham was lukewarm. The ground meat dry. The mixed vegetables nd the mashed potatoes had				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00755	B. WING		02/2	27/2014
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOOD S	AMARITAN SOCIETY		INGER MEMO IN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 960	Continued From pa	ge 11	2 960			
	The Director of diet policies and proced for nutritive and pal committee could be	THOD FOR CORRECTION: ary could review and revise lures to ensure compliance atable food. A dining developed for residents.				
21015	Requirements- Sau Subp. 7. Sanitary procedures and cor	0 Subp. 7 Dietary Staff nitary conditi conditions. Sanitary nditions must be maintained in e dietary department at all	21015			
	by: Based on observati review, the facility f dietary kitchen, faile to prevent cross co milk based supplen refrigerator storage under sanitary cond	ent is not met as evidenced on, interview and document ailed to maintain a clean ed to serve food in a manner ntamination, failed to monitor nents for appropriate and failed to serve foods ditions which had the potential lents who consumed food chen.				
	the following observ (1) Two metal carts splattered with food (2) The cupboard d	s in the kitchen that were				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00755	B. WING		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER	•	DDRESS, CITY, S	TATE, ZIP CODE	, <u> </u>	
300D S	AMARITAN SOCIETY		INGER MEMO			
		MOUNTA	NN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21015	Continued From pa	age 12	21015			
	window up and dow serving area) was o grease and dust; (4) The tract for the grease and dust in (5) The top shelf of caked with dust and (6) Dried food and sides of the stove a (7) A greasy, dusty which held 3 food th were stored with per The following proble the initial kitchen to included: (1) In the walk in co ham dated 2/6/14 in with the dietary aide to be thrown after 7 ham should have b in the refrigerator 1 (2) 3 containers of were thawed and n containers; (3) uncovered slice the walk-in cooler; should not have be and not dated; (4) 6 cups of puddin cooler, uncovered at (5) a pack of turke manufacturers date when opened and t long it had been op	used to pull the serving vn (which is directly over the coated with a thick layer of e serving window also had the tract; f the stove was observed to be d grease; grease were noted down the and the steamer; and v cup located on the counter hermometers without covers, encils, scissors and markers. ems were also noted during our on 2/24/14 at 9:10 a.m. and poler there was a package of n a plastic container. Interview e (DA)-A stated that food was 7 days of opening and that the even discarded as it had been 8 days; thawed whipped topping that o open date identified on the es of pies located on plates in DA-A stated that the pie en in the walk-in uncovered ng located in the walk-in and undated; y breast lunch meat that had a e of 1/20/14 but not dated the DA-A did not know how				
		n. during the observation of the				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/27/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
000 5	AMARITAN SOCIETY		INGER MEMO			
		MOUNTA	IN LAKE, MN	56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21015	Continued From pa	age 13	21015			
	had 8 glasses of ju containers of half a and had a manufac 2/24/14 and 16 con 2 (a milk based sup	located near the serving area ice uncovered and 4 and half that were not dated cturers stamp of use by tainers of thawed Hormel Plus oplement) without dates to were removed from the l.				
	PLUS - 2 from the Conditions: KEEP I	mendation for the Hormel company is "Storage FROZEN. Storage After Open Life After Open: Up to 14 days ."				
	4:50 p.m. cook- Av temperatures. The squash, tuna melt, sandwiches with sh Cook A retrieved ar from her pocket. Co of the 3 containers digital thermometer remove the food th located on the cour the digital thermometer and then dropped t Cook -A removed th of tongs, wiped it w continued to check food items. It was r with soup so she re retrieved another p p.m. At this time th instructed cook-A to responded, "why, I	meal on 2/26/14, beginning at was observed to take food meal consisted of: beans, vegetable soup, Philly beef predded cheese and crackers. Ind donned a pair of gloves ook-A tested the temperature of vegetable soup with a blue r and then proceeded to ermometer from the dirty cup heter. She wiped only a portion retrieved from the soiled cup he thermometer into the soup. he thermometer with the use with an alcohol wipe and the temperatures of the other noted her gloves were soiled emoved the soiled gloves and air from her pocket at 5:00 he dietary manager (CDM) to wash her hands. Cook-A had gloves on?" but then and donned another pair of				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/	27/2014
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	ge 14	21015			
	following was noted to have disposable reached out and ha which included the oven mitts on, takin sorting through resi same soiled gloves buns out of the pac individual cheese s	tarted at 5:03 p.m. and the d: Cook-A, who was observed gloves on both hands, undled contaminated surfaces outside of the steamer, putting of food out of the oven and dent menu slips. With the , Cook- A retrieved individual kage for sandwiches, handled lices to place on sandwiches al saltine crackers on resident				
	serve individual pla picking up individual crackers with there observed to open c kitchen drawers and microwave, with the Cook-A was also of of bread out of a pla the toaster, with the buttered the toast, of her hand on her shi	s observed to continue to tes of food for residents, al buns, cheese slices and gloved hands. Cook-A was upboard doors, steamer lid d open the refrigerator and e same soiled gloved hands. oserved to remove two pieces astic bag and put the slices in e same soiled gloves. She opened the oven door, wiped irt and then continued to serve buns, crackers and cheese er gloves.				
	serve individual boy When questioned if	A was observed to start to wls of the contaminated soup. the contaminated soup she stated "why not."				
	p.m. she verified th located on the back that staff do not dat from the freezer so	th the CDM on 2/26/14, at 3:45 at the boxes of Plus 2 were s shelf of the refrigerator and the the boxes when removed there was no system to of the time the supplements	5			

	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/	27/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		INGER MEMO AIN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From no	~ 15	01015	DEFICIEN	CY)	
21015	verified the milk-ba	gerator once thawed. CDM sed containers should be ed from the freezer, thawed	21015			
	2/27/14, at 8:45 a.n change gloves betw soup should not ha have been removed the soiled thermom the food item. She thermometers shou soiled cup, should in food temperatures. rationale for using the verified that staff we	Id not have been stored in a not have been utilized to check The CDM was unaware the he cup for storage. She also ould be expected to utilize kers, the buns and the cheese				
	kitchen, the CDM v and grease, dirty ca steamer, soiled cha (which she stated s had never been cle CDM confirmed she schedule. When th regarding the clean "what cleaning schedule i	v of the dirty condition of the erified the presence of dust arts, soiled stove, soiled ain above the window and track the had not even noticed and aned but should be.) The e had just started a cleaning the surveyor questioned Cook-E ing schedule, she replied, edule?" Upon discovery of the t was noted that nothing had and indicated that they were that schedule.				
	Gloves revised Mar "Gloves are to be c handling "ready to e contact with somet	Procedure titled, Sanitation rch 2009, instructs that hanged as follows: a. Before eat" foods. b. When coming ir hing that is contaminated such can or touching a door knob o				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/	27/2014
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	• • • • • •	
GOOD SA	AMARITAN SOCIETY		INGER MEMOR AIN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	ge 16	21015			
		ezing, coughing or touching After coming in contact with				
	The Administrator a and revise food ser to assure that food manner. Staff coul The Certified Dieta service of food on a					
	One (21) days.	R CORRECTION: Twenty-				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 4 Tuberculosis ntrol	21426			
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide	e provider must establish and hensive tuberculosis ogram according to the most is infection control guidelines d States Centers for Disease tion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of te technical assistance intation of the guidelines.				
	(b) Written complia be maintained by th	ance with this subdivision musi ne nursing home.	t			

ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
	00755	B. WING		02/27	
ME OF PROVIDER OR SUPPLIE	R STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OOD SAMARITAN SOCIET	Υ - ΜΟΠΝΤΔΙΝΤΙΔΚ	NGER MEMO NN LAKE, MN			
REFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21426 Continued From	bage 17	21426			
by: Based on intervie facility failed to ac skin test (TST) fo	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:					
Review of the impreceived a first st and was read on 0 millimeters (mn	d to the facility on 1/7/14. munization record indicated R72 ep tuberculin skin test on 1/7/14 1/10/14 with a negative result of n) induration. The record did no d step TST had been	-			
director of nursing January 2014 and	on 2/27/14 at 1:40 p.m. the g (DON) confirmed that starting d since that time, the facility had je of Mantoux (TST) solution.				
registered nurse	on 2/27/14 at 3:12 p.m. (RN)-A confirmed that a 2nd t administered to R72.				
Residents for Tuk includes: "A two-s used for TST whe This involves adm admission, which a nursing profess TST is negative, placed one to thre	dure titled Screening of berculosis revised 11/13 step Mantoux method should be en testing in the care center. hinistering the initial test upon is read within 48 to 72 hours by ional or physician. If the first the second test should be be weeks after the placement of a second test is read 48 to 72 histration."	,			
SUGGESTED MI	ETHOD OF CORRECTION:				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			_				
		00755	B. WING		02/	02/27/2014	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
GOOD S	AMARITAN SOCIETY		INGER MEMOI				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21426	Continued From pa	age 18	21426				
04-500	development and ir procedures for tube Center for Disease The director of nurs then monitor the ap to the policies and TIME PERIOD FOR (21) days	R CORRECTION: Twenty one					
21530	A. The drug regim reviewed at least m currently licensed b This review must b Appendix N of the S Surveyor Procedure Requirements in Lo the Department of Health Care Finand This standard is in available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upon physician visit, or s pharmacist. For pu upon" means the a report and the sign of nursing services C. If the attend with the pharmacist not provide adequa pharmacist believe	0 A.B.C Drug Regimen Review en of each resident must be nonthly by a pharmacist by the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, cing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan ubject to frequent change. acist must report any director of nursing services ohysician, and these reports n by the time of the next ooner, if indicated by the urposes of this part, "acted cceptance or rejection of the ing or initialing by the director and the attending physician. ling physician does not concur t's recommendation, or does ate justification, and the s the resident's quality of life is ected, the pharmacist must					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	- B. WING		02/27/2014	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST		02/	21/2014
		745 BAS	INGER MEMO			
3000 5/	AMARITAN SOCIETY	- MOUNTAIN LAP MOUNTA	IN LAKE, MN	56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 19	21530			
	if the medical direct physician. If the m the attending physi justification for the physician does not must be referred for assessment and as by part 4658.0070. the medical director must refer the matt	the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality ssurance committee required If the attending physician is or, the consulting pharmacist ter directly to the quality ssurance committee.				
	by: Based on interview facility failed to ens identified irregularit indications and/or i failed to ensure sta recommendations,	ent is not met as evidenced and document review, the sure the consultant pharmacist ties related to lack of clinical nadequate monitoring, and off acted on pharmacy for 2 of 5 residents (R23 and ations were reviewed.				
	Findings include:					
	diagnosis from the form dated 12/10/ dementia, Parkinso Brief Interview for M assessment dated scored 15/15 and w physician orders in (mg) had been pres	eviewed. R23's active Minimum Data Set (MDS) 13, included hypertension, on's, anxiety and depression. A Mental Status (BIMS) 12/10/13, indicated R23 had vas cognitively intact. Current dicated Ativan 0.5 milligrams scribed for anxiety or agitation ry (PRN) up to two times per				
inesota De		cember 2013 medication ord (MAR) indicated R23 had				

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			COMP	
00755		A. BUILDING: _	·····	COMP	LETED
	00755	B. WING		02/2	7/2014
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD SAMARITAN SOCIETY -	ΜΟΠΝΤΔΙΝΤΔΚ	INGER MEMO IN LAKE, MN			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLET DATE
21530 Continued From pag	e 20	21530			
received Ativan 0.5 m following times: (1) On 12/5/14, at 6:3 and subsequent doct "calm/resting" at 7:0 (2) On 12/11/14, at 2 discomfort and the re- was documented at 4 (3) On 12/16/13, at 9 indication/reason for- upon R23 after admi (4) On 12/18/13, at 3 indication/rationale n medication; (5) On 12/20/13, at 9 rationale for use with (6) On 12/27/13, at 2 "c/o (complaints of) g documentation lackin the medication; and (7) On 12/30/13, at 9 administered for anx response to the med A review of the Janua Ativan 0.5 mg had be dates: (1) On 1/3/14, at 5:3 an indication for use response; and (2) On 1/9/14, at 7:30 anxiety without docu anxiety symptoms no responded to the me	ng for anxiety during the 30 p.m. given for agitation umentation revealed 10 p.m. 1:35 p.m. for general esponse to the medication 4:30 p.m. "Resting quietly." 1:15 p.m. with no administration nor effect nistration of the medication; 3:00 p.m. with no or results from receiving the 0:30 p.m. with no indication or no results documented; 2:10 p.m. Ativan given for general pain/restless" with ng to indicate the response to 9:30 p.m. Ativan iety and no resident ication documented. ary 2014 MAR indicated een given on the following 30 p.m. administered without nor documented resident 10 p.m. administered for mentation describing the or whether the resident				

	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/27/2014	
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		02/	21/2014
		745 BAS	INGER MEMO			
000 5/	AMARITAN SOCIETY	- MOUNTAIN LAP MOUNTA	IN LAKE, MN	56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21530	Continued From pa	age 21	21530			
	conducted and the Problems" on 12/12 indicating no drug p for R23. The form of pharmacist. During pharmacist on 2/27 pharmacist verified been addressed in December 2013, Ja 2014. During interview wit 2/27/14, at 9:30 a.m been no recommer regarding R23's int Ativan without adec monitoring of the m R46's record was m indicated the reside 5/3/11 with diagnos physician orders ind restarted on Prozac mouth) daily on 2/2	ew Documentation was pharmacist had recorded "No 2/13, 1/13/14 and 2/12/14, problems had been identified was signed by the consultant interview with the consultant 7/14, at 8:40 a.m., the R23's use of Ativan had not the pharmacy reviews for anuary 2014 or February th the director of nursing on n., the DON verified there had adations from the pharmacist ermittent use of the medication quate indications for use and/on hedication's effectiveness. eviewed and the face sheet ent had been admitted on the been admitted on the sincluding depression. The dicated R46 had been to 10 mg (milligrams) po (by 15/13.				
	form from the cons 8/10/13, included: " is due for: Prozac dose response obs depressive/dement reduction if no long	ulting pharmacist, dated Six month drug re-evaluation 10 mg daily. Please documen erved for controlling target ia symptoms or attempt dose er needed". The form lacked esponse from either the	t			
	director of nursing had not attempted	2/27/14, at 1:45 p.m. the (DON) confirmed the physiciar a GDR or provided rationale continue on the medication				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/27/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		INGER MEMO AIN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	age 22	21530			
	The DON confirme monitoring form da pharmacist had not physician for review recommendation. SUGGESTED MET	ng the medication on 2/25/14. d the Behavior-Medication ted 8/10/13 from the t been communicated to the v of the pharmacy THOD OF CORRECTION: d/or director of nursing could				
	in-service and mon maintaining a funct pharmaceuticals se ensure monthly reg	itor for compliance with				
	(21) days.					
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			
	monitor each reside unnecessary drug u home's policies and pharmacist must re- resident's attending physician does not home's recommend adequate justification believes the reside adversely affected, matter to the medic medical director is the medical director physician does not the order and if the change the order, t review to the Qualit	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00755	B. WING		02/	02/27/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
iOOD S	AMARITAN SOCIETY		INGER MEMO IN LAKE, MN				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE DATE	
21540	Continued From pa	age 23	21540				
		ician is the medical director, rmacist shall refer the matter					
	by: Based on interview facility failed to ens R23) drug regimen medications. The gradual dose reduc antidepressant me rationale for contin ensure adequate n the use of an antia Findings include: R46's record was n indicated the reside 5/3/11 with diagnos physician orders in restarted on Proza mouth) daily on 2/2 Patient Health Que used to determine 12/11/13, indicated	dication, failed to provide ued usage, and failed to nonitoring was conducted for					
	identified R46 had behavior related to anxiety, and increa complaints of not for Care plan approac through 2/25/14, in	are plan dated 12/18/13 an alteration in mood and episodes of withdrawal, used confusion as evidenced by eeling well and tearfulness. hes reviewed from 8/31/13 dicated R46 had no episodes eneral physical complaints me.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE	I •	
GOOD S	AMARITAN SOCIETY	- ΜΟΠΝΤΔΙΝΤΔΚ	INGER MEMO NN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From pa	ge 24	21540			
	form from the cons 8/10/13, included: " is due for: Prozac dose response obs depressive/dement reduction if no long	avior-Medication monitoring ulting pharmacist, dated Six month drug re-evaluation 10 mg daily. Please documen erved for controlling target ia symptoms or attempt dose er needed". The form lacked esponse from either the physician.	t			
	director of nursing had not attempted as why R46 should Prozac since startin The DON confirme monitoring form da	2/27/14, at 1:45 p.m. the (DON) confirmed the physician a GDR or provided rationale continue on the medication ng the medication on 2/25/14. d the Behavior-Medication ted 8/10/13 from the been communicated to the v of the pharmacy	T			
	administration reco received Ativan 0.5 at 9:15 p.m. and ha 12/17/13, at 12:35 later). In addition, 1 received Ativan 0.5 and had experience	eviewed. The medication rd (MAR) indicated R23 had mg (antianxiety) on 12/16/13, id experienced a fall on a.m. (3 hours, 20 minutes the MAR indicated R23 had mg on 12/30/13 at 9:30 p.m., ed another fall on 12/31/13, at & 50 minutes later).				
	Set (MDS) form da hypertension, deme depression. This M a history of falls ha to admission. A Brid (BIMS) assessment	osis from the Minimum Data ted 12/10/13, included entia, Parkinson's, anxiety and DS further indicated R23 had ving occurred 2-6 months prior ef Interview for Mental Status t dated 12/10/13, indicated /15 and was cognitively intact.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00755	B. WING		02/27/2014		
IAME OF F	PROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE, ZIP CODE				
2000 S	AMARITAN SOCIETY	- MOUNTAIN LAK 745 BAS	INGER MEMOR	RIAL DRIVE			
		MOUNTA	AIN LAKE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21540	Continued From pa	age 25	21540				
	"Comfort: Alteration (degenerative joint chronic low back pa being difficult to ma "Yelling at staff: offe (significant) pain; m care plan included; R/T depression, an history of being cor berating staff prior out when experient included; " Explain cares and procedur anxious or experier behavior; calls out of pain level and repo communication sec included: "Deficit in dementia; also has agitation, anxiety w causing difficulty wi plan of care address consequences R/T and directed the sta consequences of a A review of the doc Monthly Drug Revie conducted and the Problems" on 12/12 indicating no drug p for R23. The form w pharmacist.	ction of the plan of care cognitive changes R/T a history of confusion, ith increased pain level ith comprehension." R23's seed the potential for adverse current medication regime aff to monitor for adverse Il medications. umentation on the form titled, ew Documentation was pharmacist had recorded "No 2/13, 1/13/14 and 2/12/14, problems had been identified was signed by the consultant	5				
	(mg) was prescribe	dicated Ativan 0.5 milligrams ed for anxiety or agitation ry (PRN) up to two times per					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/27/2014	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		02/	21/2014
		745 BAS	INGER MEMO			
aood Si	AMARITAN SOCIETY	- MOUNTAIN LAP MOUNTA	AIN LAKE, MN	56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21540	Continued From pa	ige 26	21540			
	drug used to treat a included, "Older ac the side effects of t coordination and dr may not experience lorazepam. It may h elderly, causing syn changes, sleeping p interest, or hallucin	AD, Ativan/Lorazepam is a anxiety. The WebMD site dults may be more sensitive to his drug, especially loss of rowsiness. Also, the elderly e the relief of anxiety with have the opposite effect on the nptoms including mental/mood problems, increase in sexual ations. Loss of coordination reping problems may increase	,			
	R23 had received A during the following (1) On 12/5/14, at 6 and subsequent do "calm/resting" at 7 (2) On 12/11/14, at discomfort and the was documented a (3) On 12/16/13, at indication/reason for upon R23 after adm (4) On 12/18/13, at indication/rationale medication; (5) On 12/20/13, at rationale for use wi (6) On 12/27/13, a "c/o (complaints of) documentation lack the medication; and (7) On 12/30/13, at administered for an	 3:30 p.m. given for agitation cumentation revealed 3:00 p.m. 2:35 p.m. for general response to the medication t 4:30 p.m. "Resting quietly." 9:15 p.m. with no or administration nor effect ninistration of the medication; t 3:00 p.m. with no nor results from receiving the 9:30 p.m. with no indication or th no results documented; t 2:10 p.m. Ativan given for general pain/restless" with sing to indicate the response to the response t				
	•	uary 2014 MAR indicated				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00755	B. WING		02/27/2014		
AME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
	AMARITAN SOCIETY	- MOUNTAIN LAN 745 BAS	INGER MEMO IN LAKE, MN	RIAL DRIVE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21540	Continued From pa	ge 27	21540				
	dates: (1) On 1/3/14, at 5 an indication for use response; and (2) On 1/9/14, at 7: anxiety without doc anxiety symptoms of responded to the m Documentation was related to consisten use of the Ativan. During interview with on 2/27/14, at 8:40 R23's use of Ativan pharmacy review for 2014 or February 2 During interview with 2/27/14, at 9:30 a.m been no recommen regarding R23's inter Ativan without adec monitoring of the m SUGGESTED MET The Director of Nur psychoactive medic to meet the require regulations. A quali implemented to ensi- medications are mo-	s lacking in the record for R23 at side effect monitoring for the th the consultant pharmacist a.m., the pharmacist verified was not addressed in the or December 2013, January 014. The director of nursing on n., the DON verified there had idations from the pharmacist ermittent use of the medication quate indications for use and/or redication's effectiveness. THOD OF CORRECTION: rsing could review the use of cations with the licensed staff ments of the state and federal ty assurance audit could be sure that psychoactive ponitored and reported to the					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00755	B. WING		02/	02/27/2014	
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
2 000	AMARITAN SOCIETY		INGER MEMO				
		MOUNTA	IN LAKE, MN	56159		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
21665	Continued From pa	age 28	21665				
21665	MN Rule 4658.140	0 Physical Environment	21665				
	functional, comforta environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible.					
	by: Based on observat review the facility fa environment was n manner by ensurin of 2 resident rooms strong urine odor p and failed to ensure in resident bathroo R43, R48, R65 and within a safe range	naintained in a comfortable g odors were addressed for 2 s (R13 & R48) that had a present throughout the survey e that hot water temperatures ms (R3, R13, R22, R36, R42, d R102) were maintained and this had the potential to ent bathrooms checked for hot					
	Findings include:						
	2/26 and 2/27/14, t	lay of the survey 2/24, 2/25, here was a strong urine odor sent in R13 and R48's nrooms.					
	Interview for Menta completed on 11/22 which indicated the and the resident wa aware of the urine	eviewed. According to a Brief al Status (BIMS) assessment 2/13, R13 had a score of 15/15 e resident's cognition was intac as interviewable. R13 was not odor smell in the room but did of want visitors in the room with	t				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00755	B. WING		02/	02/27/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		INGER MEMO IN LAKE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21665	Continued From pa	ge 29	21665				
	room, he was unaw made to clean pers of the smell had be the urine odor was When interviewed of nursing assistant (N to cover it up [the u smells. They have to to cover the smell." the product utilized label on the produc Tuscan garden odo						
	(DON) at 1:15 p.m. administration was	th the director of nursing on 2/26/14, the DON verified aware of the odor in R13's t has been a problem since re."					
	services (DES) on 2 urine odor was obs odor was also notic tour the administrat	nental tour with the lirector of environmental 2/27/14 at 2:30 p.m., a strong erved in R48's room. The ed in the hallway. During the for and DES verified the odor. acility did not have a policy for					
		eviewed. According to the en assessed to have severe nt as not able to be					
	2:00 p.m., the DON in R48's room could	with the DON on 2/27/14, at I stated the urine odor present I be due to the resident's use er, but agreed that odor ddressed.					

ATEMENT OF DEFICIEN			E CONSTRUCTION		E SURVEY PLETED	
	00755	B. WING	B. WING		02/27/2014	
AME OF PROVIDER OR S		STREET ADDRESS, CITY, S	TATE, ZIP CODE			
OOD SAMARITAN S	OCIETY - MOUNTAIN I AK	745 BASINGER MEMO MOUNTAIN LAKE, MN				
REFIX (EACH D	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY F ORY OR LSC IDENTIFYING INFORMAT	ID FULL PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21665 Continued	From page 30	21665				
a.m. with th environmer checked in each wing a end of the Temperatur noted in the (1) Resider R43-122 de (2) Resider 124 degrees; an	t 300 wing: R42-125 degrees	of ires were ns on nd the wing. t and es, t, R13- 22				
maintenand recommend 115 degree maintenand hot water h weeks ago heater was verified the	ith the administrator and direct e on 2/27/13, at 9:30 a.m. ver ded state temperatures can go s for domestic water. The direct e shared that the facility had a eater installed and stated, "A of maybe a month since the hot put in." The director of mainter water temperatures had not b note the new hot water heater h	rified the o up to ector of a new couple of t water enance been				
Temperatur 2006 read, and record needed or	policy titled, "Water re/Hardness Record" dated No "These checks should be con ed a minimum weekly or more required. Recommended chec undry, kitchen and one reside	npleted e often if ck areas				
	ED METHOD OF CORRECTI r designee could educate staf					

	ta Department of He					SURVEY
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
		00755	B. WING		02/2	27/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NGER MEMO IN LAKE, MN			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21665	Continued From pa	ge 31	21665			
	frequent to ensure	idits of areas residents a safe and home like ained to the extent possible.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21695	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			
	provide housekeep necessary to mainta comfortable interior	eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, ixtures, equipment, lighting,				
	by: Based on observati review the facility fa in 4 of 4 resident ha wings) in a safe and	ent is not met as evidenced on, interview and document illed to maintain the floor tiles allways (100, 200, 300 and 400 d sanitary manner; and failed ceiling tiles in 2 of 4 resident 400 wings).				
	Findings include:					
		irector of environmental ::00 p.m. on 2/27/14, the				
	hallways observed build up of wax. The be 12 inch square v	he length of the resident to be stained and to have a e floor tiles were observed to vhite tiles. Numerous floor tiles hallways had become				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00755	B. WING		02/	27/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		INGER MEMO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21000	 Continued From page 32 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 		21695			
	was another crack At the entrance of t cracked tiles were stated during the to from the building so wear and tear.	that spread across 5 floor tiles the 400 wing, one section of observed. The administrator our that the cracks could be ettling/shifting or just normal				
	were observed to h areas present. Sou discolored a dark ta blackish discolorati	wn the 200 and 400 wings have numerous large stained me of the tiles appeared an/gray color and others had a on. The administrator verified ceiling tiles should be				
	administrator and I cause for the disco The floor care pers interviewed at that process for waxing floors were waxed provide care to resi halls. FCP-B furthe strip of the original fresh wax. FCP-B s product called "GP remove the old wax	on 2/27/14, at 2:30 p.m. the DES were not sure of the lored areas on the floor tiles. connel, (FCP)-B was same time and described the the floors. FCP-B said the in "strips" so staff could idents who lived down the er stated staff did not routinely wax prior to application of a said the staff utilized a new Forward" which did not x very well. The DES verified p had not been stripped from				

	NT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/27/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		INGER MEMOI AIN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From pa	ige 33	21695			
	administrator could to report timely env can be addressed t sanitary environme visitors.	THOD OF CORRECTION: The in-service all staff on the need ironmental concerns so they imely to provide a safe and nt for the residents, staff and	ł			
	(21) days.	R CORRECTION: Twenty One				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observat review, the facility f dining experience f R13, R26, R31, R3	ent is not met as evidenced ion, interview and document ailed to provide a dignified or 11 of 52 residents (R10, 2, R36, R39, R45, R53, R65 & served during meal service.				
	Findings include:					
	11 residents (R10, R39, R45, R53, R6 interviewed, expres	xperience was not provided for R13, R26, R31, R32, R36, 5 & R75) who when seed dissatisfaction with not meals at the same time as				
		on 2/25/14, at 11:40 a.m. R10 it, they don't serve the entire				

	a Department of He OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00755	B. WING		02/	02/27/2014	
	ROVIDER OR SUPPLIER		DDRESS, CITY, ST		02/	27/2014	
		745 BAS	INGER MEMO				
OOD SA	MARITAN SOCIETY		IN LAKE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	ge 34	21805				
	room but how do th to tablemate's finish got mine. At first I for getting used to it." If dissatisfaction had numerous occasion medical record, R1 Mental Status (BIM which indicated coor During subsequent 2/26/14 at 5:44 p.m the dining room with expressed frustration seated at the table not yet received he residents at R10's to	by how you come to the dining ley know? It was hard to adjus hing their food before I even elt awkward but now I'm R10 verified that her been expressed to the staff or is. According to review of the 0 had a Brief Interview for S) score on 10/1/13, of 15/15 gnitively intact. observation/interview on a. R10 was observed seated in h 3 tablemate's. R10 on stating that she had been since 5:05 p.m. and still had r food. Two of the three other cable had finished their evening ind R31 waited for their food to	t 1				
	stated, "I'm not hun get you down here with no food while t principal should be don't like this and I interview on 2/26/14 alone eating the no meals were not enji wait for meal service questioned about the identify the meat sh "I don't know what the dry." R13 verified d served had been ex- times. R13 had a E	on 2/25/14, at 5:39 p.m. R13 gry, but the principal is, they to get the food and you wait he others at the table eat. The to all eat at the same time, I feel left out!" During an 4, at 1:00 p.m. while seated on meal, R13 verified the oyable because of the long the and delivery of food. When he meal, R13 was unable to he had been eating and stated, this is, I really don't, it is so issatisfaction with the meals kpressed to the staff numerous BIMS score on 11/27/13, of ed cognitively intact.					
	During an interview	on 2/25/14, at 11:15 a.m. R26					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00755	B. WING		02/27/2014	
					02/21/2014	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOOD S	AMARITAN SOCIETY		INGER MEMO NN LAKE, MN			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21805	Continued From pa	age 35	21805			
	is uncomfortable to served at the same R26 verified that di service had been en numerous occasion 1/29/14, of 13/15 w intact. During observation p.m. R31 was obser with 3 tablemate's. served their meals; observed finishing she had been waiti p.m. (34 minutes) t waited even longer with the time waitin eating at different to R31 confirmed that often. R31 had a E	be served at the same time, it e eat when everyone is not e time. It's just good manners." ssatisfaction with the meal expressed to the staff on ns. R26 had a BIMS score on which indicated cognitively //interview on 2/26/14, at 5:44 erved seated in the dining room R31 and R10 had not been their meal. R31 confirmed tha ng since approximately 5:10 to be served and that R10 had c. R31 expressed frustration g to be served and also with imes than her tablemate's. t this occurrence happened BIMS score on 1/16/14, of ted cognitively intact.	1			
	During an interview expressed dissatist meal service while were served first. F you do, but I don't I before me when I w don't like watching get served with the received her meal a receive her meal un later). During an im p.m. after waiting 3 service, R32 stated because I always h is not good." R32 w	y on 2/25/14, at 11:20 a.m. R32 faction with the long wait for others who arrived after her R32 stated, "I'm ok, what can ike watching others get served was here before them and I other people eat when I don't m." Another lady at the table at 11:15 a.m. and R32 did not ntil 11:40 a.m. (25 minutes nterview on 2/25/14, at 5:39 99 minutes for supper meal d, "This makes me angry have to wait so long. This delay verified dissatisfaction with the peen expressed to the staff on				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00755	B. WING		02/	02/27/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		INGER MEMO				
		MOUNTA	IN LAKE, MN			1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	age 36	21805				
	10/1/13, of 9/15 wh cognition impairme	ich indicated moderate nt.					
	a family member (F the FM stated, "It is in this room and wa is whoever comes takes 45 minutes o servers and who th to get service." R36 watch others eat m minute." F36 verifie expressed to the st R36 had a BIMS so	on 2/25/14, at 5:50 p.m. while FM) was seated next to F36, a not uncommon to have to sit ait 45 minutes to be served. It first gets served first but it still f waiting. It depends on the e staff are for how long it takes 5 stated, "Having to wait and akes me hungrier by the ed dissatisfaction had been taff on numerous occasions. core on 10/1/13, of 99 which ent was unable to complete the					
	stated, "If you come you come first you but I am used to it table with 5 other la dissatisfaction with expressed to the st	the meal service had been aff on numerous occasions. core on 10/1/13, of 14/15 which					
	p.m. R45 was observed with 3 tablemate's. seated at the table 5:30 p.m. and R45' remain seated at the residents consume that no ever received time so they can earrive at 5:00 p.m. 'Sometimes it is a h	/interview on 2/26/14 at 5:45 erved seated in the dining room Two of the three residents had received their meals at s tray arrived at 5:45 p.m. R53 he table while the other three d their food. R45 indicated es their meals at the same at together. R45 stated you and sit and wait. R45 stated, half an hour, sometimes it is an IMS score on 12/4/13 of 15/15					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/	27/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NGER MEMO IN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 37	21805			
	which indicated co	gnitively intact.				
	p.m. R53 summone R53 indicated her f service as she had 5:00 p.m. R53 state You come at 5 and minutes, 45 minute our food at the sam tables received the received his meal a that R53 was serve	/interview on 2/26/14, at 5:45 ed the surveyor to the table. irustration with the meal been in the dining room since ed "it is like this all the time; you wait. It can be 30 es or an hour! We never get ne time." R53 stated that two ir meals at 5:30 p.m., R45 at 5:40 p.m. It was observed ed at 5:50 p.m. R53 had a 25/13 of 15/15 which indicated				
	stated, "It doesn't n you wait." R65 furth long "wait" times fo may be a reason fo and meats routinel with the meal servi staff on numerous	y on 2/25/14, at 11:43 a.m. R65 natter when you come here, her verified she dislikes the or meal service and thinks that or the overcooked vegetables y. R65 verified dissatisfaction ce had been expressed to the occasions. R 65 had a BIMS of 15/15 which indicated				
	75 stated "It would together". Another received the meal a later, R 75 received During an interview verified she came t and it was not unus longer to be served verified dissatisfact staff on numerous	v on 2/25/14, at 11:23 a.m. R be nice if we were all eating resident at the same table at 11:15 a.m. and 25 minutes d her meal at 11:40 a.m. v on 2/25/14, at 5:45 p.m. R 75 to the dining room at 5:00 p.m. sual to wait forty five minutes or d the evening meal. R 75 tion had been expressed to the occasions. R 75 had a BIMS of 15/15 which indicated				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00755	B. WING		02//	27/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		INGER MEMO			
		MOUNTA	AIN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 38	21805			
	during meal service "Hon". It was noted R13 was asked wh else while in the dir referred to her as " stated to the survey do they bother to p table for everyone names when my na this occurs frequent person identified as	ervations in the dining room e, dietary aides referred to R13 I on 2/26/14, at 1:00 p.m. that rether she needed anything hing room and the dietary aide Hon" several times. R13 yor, "Do you hear that? Why ut my name right here on the to see and then still call me per ame is [R13]!" R13 confirmed htly and does not want a single s using the terms: Hon, Honey ers staff to address her by	t			
	"Open Dining" read than 10-15 minutes is required to ensur	lity policy dated 8/12, titled, d, Residents do not wait more s to be served. Batch cooking re high-quality food with Food should be kept no longer n the steam table.				
	dietary manager ve	n 2/27/14, at 9:49 a.m. the prified that residents are to be ne into the dining room.				
	dietary manager (D during the supper r the residents was u indicated this was u	n 2/27/14, at 1:11 p.m. the DM) confirmed the wait time neal on 2/26/14 for some of up to an hour. The DM unusual stating, "We've and we've never found				
	anywhere that the The DM stated that half hour wait time because all resider	wait time was over a half hour. t during the evening meal a for meal service is acceptable nts tend to be present in the) p.m., "and everybody can't				
	be first". The DM of	confirmed that only two dietary esponsible for serving food to				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00755		B. WING		02/27/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		INGER MEMO AIN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 39	21805			
		and that no other staff are th food service during meal				
	The director of nurs in-service all staff or residents with resp Assessment and As develop a system to	THOD OF CORRECTION: sing or social services could on the need to treat all ect and dignity. The Quality ssurance committee could o audit employees for dignified oward residents in the facility.	1			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21870	MN St. Statute 144 Residents of HC Fa	.651 Subd. 18 Patients & ac.Bill of Rights	21870			
	residents shall have	nsive service. Patients and e the right to a prompt and se to their questions and				
	by: Based on observat review, the facility f grievances related timeliness of food s	ent is not met as evidenced ion, interview and document ailed to act upon resident to quality of food and service. This had the potential ts who received their meals tchen.				
	Findings include:					
	stated, "The food is R33 further stated	2/26/14, at 2:30 p.m. R33 on't very good here". the timeliness of food service, od and the temperature of the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BOILDING.			
		00755	B. WING		02/2	27/2014
AME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY		INGER MEMO IN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21870	Continued From pa	ge 40	21870			
	indicated that about were served meath been "taken off of s were people who us food that were com further stated, "The R33 confirmed the and stated although sprig of green on the appearance. R33 s been brought up so meetings with no in					
	expressed dissatisf stating, "Today at lu the chicken breast green bean casser give you your yogu omelet on a cold pl	2/24/14, at 12:50 p.m. R53 faction with the food served unch the noodles were cold, was dry with no gravy and the ole was not good. They will t on a hot plate and your ate! The food is usually not the They keep saying they are doesn't change".				
	reviewed and docu (1) 9/11/13- brough coffee cups are cle when coffee is serv left her table after v food; Other residen serving priority betv Lodge; [resident] al been inadequately and potatoes have According to the no resident council me	il meeting minutes were mentation included: nt up the concern of how the aned as they have been dirty red to residents; people have vaiting over an hour for their nts agreed and questioned the veen the Village and the so brought up that food has prepared; ribs have been burn been burnt and/or served raw. otes, staff in attendance at the setting had indicated the issues cated with the dietary manager				
		al residents questioned the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00755	B. WING		02/	27/2014
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		02/	21/2014
		745 BAS				
GOOD S	AMARITAN SOCIETY		AIN LAKE, MN			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE
				DEFICIENC	CY)	
21870	Continued From pa	age 41	21870			
	serving priority of w	ho gets served when for				
		ary manager verified that				
		be served on a "first come, first	t			
		out residents said that is not				
		ne dietary manager indicated				
	she would talk with dietary staff at their next meeting and also reminded residents that the					
		not include time spent waiting				
		tart of mealtimes and that she	,			
		times on videotape and talk				
	to her staff;					
	(3) 7/10/13-resident mentioned that the ice					
		y melted by the time he				
		resident were reminded to ask				
		e in freezer until the residents				
		rozen desserts; and				
		I residents stated they have ime for some meals to be				
		manager will look into it.				
	Documentation wa	s lacking to indicate the				
		mmendations expressed				
		council meetings had been				
		cussed with residents to				
	assure the grievan	ices had been remedied.				
	During interview on	n 2/27/14, at 12:58 p.m. with				
		worker (LSW) it was				
		dents concerns expressed at				
		etings are not documented or	1			
		The LSW stated that resident				
		to dining are communicated to				
		er to address and follow-up.				
		tated, "The timeliness of the end of the a long term issue and				
		oss". The LSW confirmed that	+			
	staff do not routinel		·			
		ts from the previous resident				
		less the residents bring the				
		ne confirmed they had no				

	T OF DEFICIENCIES OF CORRECTION	CALL CALL CALL CALL CALL CALL CALL CALL	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/	27/2014
IAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, ST			
GOOD S/	AMARITAN SOCIETY		INGER MEMO IN LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21870	Continued From pa	age 42	21870			
	from one meeting t the resident counci at the Quality Assur and that in the past implemented a resi dining complaints h hence, the committed discontinued. The committee had meeting	with the concerns expressed o the next. The LSW stated I meeting notes are reviewed rance (QA) quarterly meetings the QA committee had ident food committee and that had subsequently "dwindled", tee was eventually LSW further stated the food t from 8/8/11 until 4/19/12, and ed and "revamped" if				
	1:11 p.m., the DM s cooking during the September 2013, h timely manner. How cook in question wa cook at the facility. service during the c and was very unust happened in month wait time for the su to an hour for some stated she thought supper meal would residents tend to be 5:00 p.m., "and ever confirmed there we responsible for sem at mealtimes and s not utilized to help v also acknowledged	with the DM on 2/27/14, at stated the staff who had been period from June 2013 until ad trouble serving meals in a wever the DM confirmed the as no longer employed as a The DM confirmed the food current week had been slow ual stating, "This hasn't as". She further confirmed the pper meal on 2/26/14, was up e of the residents. The DM an acceptable wait time for the be a half hour because all e present in the dining room at erybody can't be first". The DM are always 2 dietary staff ving the food to the residents taff from other disciplines are with the food service. The DM I that the tuna melts served for had been overcooked and the started over".				
	Service/Dining Ope	ed, Guidelines Meal en Dining, revised 8/12 ning includes the following:				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00755	B. WING		02/	27/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		NGER MEMO N LAKE, MN	PRIAL DRIVE 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21870	Continued From pa	ge 43	21870			
	Residents do not wait more than 10 to 15 minutes to be served".					
	"Complaints or Con- included: 2. When a resident staff member expre- to a staff member r services, it will be re- non-judgmental ma- discrimination or re 3. If the problem of the staff member w information and pro- that problem. The e- documented on the #213) and submitted director. 4. If the complain services departmer services will comple (GSS #213) form up 5. The social services appropriate departr reasonably possible 6. An investigation grievances. The im- but must be thoroug persons an opportu- relevant to the com 7. The social services and to the center ac 8. If the grievance social services dire- directly to the admini-	prisal. can be resolved immediately, ill thank the individual for the oceed to take action regarding grievance will then be Suggestion or Concern (GSS d to the center social services t comes directly to the social of the the director of social et a Suggestion or Concern pon receipt of the complaint. ices director will route the cern (GSS #213) to the nent head as soon as is e n must be completed for all vestigation may be informal, gh, affording all interested unity to submit evidence plaint is not resolved, the center ctor will channel the concern mistrator. On weekends and ns that pose an immediate				

Innesota Departm TATEMENT OF DEFICIEI ND PLAN OF CORRECT	NCIES (X1) PROVIDER/SUPPLIE	MDED.	E CONSTRUCTION		SURVEY PLETED
	00755	B. WING		02/2	27/2014
AME OF PROVIDER OR		STREET ADDRESS, CITY, S			
OOD SAMARITAN	SOCIETY - MOUNTAIN LAF	745 BASINGER MEMO MOUNTAIN LAKE, MN			
PREFIX (EACH I	MARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21870 Continued	From page 44	21870			
take the m and notify recommer be forward within two 9. The so confidentia report tren committee SUGGES The admir could prov and proce resolution.	TED METHOD OF CORRECT istrator, director of nursing or ide staff education relating to dure for resident greivance an	restigation cerns will esolved ntain a s and FION: designee policy nd			