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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: F5CI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/04/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 01/04/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 01/05/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 01/26/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/09/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245278
January 5, 2016

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 - 13th Avenue
Howard Lake, Minnesota 55349

Dear Ms. Salonek:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 15, 2015 the above facility is certified for or recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

Electronically delivered
January 5, 2016

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 - 13th Avenue
Howard Lake, Minnesota 55349

RE: Project Number S5278023 and Complaint Number H5278005

Dear Ms. Salonek:

On November 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 5, 2015 that included an investigation of complaint number H5278005 which was substantiated. 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 January 4, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 18, 2015 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 November 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 5, 2015, effective December 15, 2015 and therefore remedies outlined in our letter to you dated November 20, 2015, 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Office of Health Facility Complaints
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245278	A. Building B. Wing	1/4/2016

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/15/2015**
ID Prefix **F0313** Reg. # **483.25(b)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/15/2015**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **12/15/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	1/5/2016	28598	1/4/2016
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/5/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245278	A. Building B. Wing	1/4/2016

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	12/15/2015	ID Prefix F0313 Reg. # 483.25(b) LSC	12/15/2015	ID Prefix F0412 Reg. # 483.55(b) LSC	12/15/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	1/5/2016	10562	1/4/2016
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/5/2015

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245278	A. Building 01 - MAIN BUILDING 01 B. Wing	12/18/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0062	12/15/2015	ID Prefix Reg. # NFPA 101 LSC K0144	11/04/2015	ID Prefix Reg. # NFPA 101 LSC K0147	11/04/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/KJ	1/5/2016	34764	12/18/2015
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/3/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: F5CI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NE II 12/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/08/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 12/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 20, 2015

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

RE: Project Number S5278023 and Complaint number H5278005

Dear Ms. Salonek:

On November 5, 2015, 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. In addition, at the time of the November 5, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5278005 that was found to be substantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Brenda.Fischer@state.mn.us
Telephone: (320) 223-7338 Fax: (320) 223-7348

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 December 15, 2015, 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 December 15, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the

level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 5, 2016 (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 May 5, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies.

All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
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Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. An investigation of complaint H5278005 was completed, and substantiated during the survey at F157, F313, F412. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in	F 157		12/15/15

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

Electronically Signed | 11/25/2015

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F 157	Continued From page 1 §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the residents legal guardian, family member (F)-A, with medication changes, and missed dental and vision visits for 1 of 1 residents (R32), who had a legal guardian. Findings include: R32's quarterly minimum data set (MDS) dated 8/19/15, indicated the resident was cognitively intact, and had dementia and schizophrenia. R32's care plan dated 8/13/15, indicated the resident had, "Psychosocial well being problem related to schizophrenia and may believe ideas that she receives are real, or verbalizes, or hallucinates these ideas." R32's medical record contained a notarized document dated and signed 5/01/08, which	F 157	1) Medication change: The Namenda was restarted on 08/07/2015. The resident R32's legal guardian, Family member (F)-A was made aware on 08/07/2015 that the medication was restarted. Care conference held on 11/19/2015, with Family member (F)-A present via phone. All current medications were reviewed with family member, advised of risks and benefits of each medication. Missed dental and vision visits: Facility staff communicated with Family member (F)-A on 11/11/15 regarding her desire to enroll the resident, R32, in new company providing On-Site services. Family member wanted resident enrolled in Podiatry and Hearing, but declined Vision and Dental services, as she will continue to take her out for these services. Care	

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F 157	Continued From page 2 indicated Guardianship for R32 appointed to family member (FM)-A, "Having been appointed Guardian of the above named [R32] ward by the court is qualified and hereby authorized to act as guardian(s) with all the powers and authority prescribed by statute as shown on the order appointing the guardian, the terms of which are incorporated herein by reference including the powers: All of the rights and powers on behalf of the ward under Minn. Stat. 524.5-313 subd. (c)." During interview 11/3/15, at 6:03 p.m. F-A stated she was the guardian for R32's medical decisions, and the facility had discontinued R32's namenda (medication to treat dementia related to Alzheimer's disease) with out her consent or input. F-A stated she did not realize the medication was stopped until R32 went to see her neurologist/psychiatric doctor and they did not want her taken off the namenda. The facility had also informed F-A a dental company would come out to the facility and provide dental and vision services for R32, however, neither services were provided and she was not informed. F-A stated she felt as R32's legal guardian, she should be made aware of all changes. A Chemical Restraint/Behavior Committee form dated 4/9/15, indicated R32 was receiving namenda 10 mg (milligrams) orally, twice a day. The form was sent to R32's primary physician by the facility requesting, "May we try reduction as side effects of medication side effects potentially outweighs benefit. Will monitor for increased symptoms of dementia and decrease in cognition." The physician responded on 4/15/15, to decrease Namenda to 5 mg in the a.m., and 10 mg in the p.m. An additional request was sent to R32's primary physician by the facility on 6/22/15,	F 157	conference held on 11/19/2015, with Family member (F)-A present via phone. Family member stated she sent the paperwork to Centra Sota Oral Surgeons and they should be contacting the facility for medical records. Resident is next scheduled to see the eye doctor 1 year from last appointment (which would be 07/02/2016). 2) Medication change: All residents with medication changes that have occurred in the last 30 days will be reviewed to ensure the resident or resident's legal guardian was notified of the change. Missed dental and vision visits: All residents will be reviewed to ensure all are current on dental and vision visits as ordered. 3) Medication change: Review and re-education of GSS policy and procedure for notifying residents or legal guardians of medication changes was provided to all nurses by 12/15/2015. Missed dental and vision visits: Review and re-education of GSS policy and procedure for providing dental and vision services as well as notifying resident and family and offering alternative services if current provider unable to see timely will be provided to facility appointment scheduler and all nurses by 12/15/2015. 4) Medication change: All medication order changes will be audited weekly x 4, then monthly x 2 months to ensure proper	

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F 157	Continued From page 3 which indicated, "May we d/c (discontinue) Namenda. Past reduction has gone well." The physician responded on 6/29/15, to discontinue namenda. A Clinic Referral form for R32 dated 8/7/15, indicated the resident had been seen by her neurologist/psychiatric doctor and was ordered R32 to restart namenda 10 mg twice a day. During interview 11/04/15, at 12:36 p.m. with the director of nursing (DON) who stated she was not aware that FM-A was R32's guardian. The DON stated she did not inform R32's F-A of the medication changes and should have since she is the guardian. R32's Health and Vision form dated 9/3/14, indicated the resident had seen an eye doctor for open angle glaucoma (complicated disease in which damage to the optic nerve leads to progressive, irreversible vision loss) with borderline intra ocular pressure pseudophakia (a complicated disease in which damage to the optic nerve leads to progressive, irreversible vision loss of both eyes). The document indicated R32 was to return to the eye clinic in 6 months, and was required to check intra ocular pressure every 6 months. R32's facility Progress Note dated 6/2/15, indicated R32 was, "Experiencing complaints of cloudiness and black dot obscuring vision in R (right) eye. Writer faxed communication request for service to in house [eye doctor] to be seen on Friday, 5/29/15. Writer followed up Monday with still no response or indication they would come and see her. Writer LM [left message] with [F-A]. [F-A] called back this morning and stated she would be making an appointment [with eye	F 157	notification was completed. Results will be reported to QAPI for further recommendations. Missed dental and vision visits: All ordered dental and vision appointments or follow-up visits will be audited monthly, x 3 months to ensure proper notification was completed. Results will be reported to QAPI for further recommendations.	

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F 157	Continued From page 4	F 157		

doctor] to have her seen since we weren't getting anywhere. Daughter also expressed concern about residents dental care."
A clinic referral from the eye doctor dated 6/4/15, indicated R32 now had, "Early macular hole OD (right eye) glaucoma OD>OS (OS left eye) macular degeneration." The Referral indicated date of next appointment to be in one month.
R32 was seen for the follow up appointment at the off site eye doctor on 7/2/15.
Although R32 was seen by the eye doctor on 9/3/14, and was directed to have a follow up appointment in 6 months, the facility did not initiate a follow up appointment, nor notify FM-A the in house eye doctor was unable to follow up with R32, until the resident began to experience problems with vision, which was almost 9 months later.
R32's medical record indicated a dental referral was completed on 7/14/14, and she was seen by a DDS (doctor of dental surgery) and the referral indicated, "Pt (patient) has upper and lower partial dentures that fit well. Pt has no concerns at this time. No decay noted. Existing restorations are in good condition." The Referral directed R32 was to return for a follow up visit in 6 months. The facility sent an e-mail to the in house dentist on 4/04/15, (nine months later) indicating R32 had a previous recommendation to have a follow up dental appointment. The response email from the in house dental clinic indicated the family would have to pay $119 in between the yearly visits since (MA) medical assistance would not cover the visit. R32 was not seen again by a dentist until 9/24/15, 14 months after the initial dental appointment. The follow up dental appointment on 9/24/15, indicated R32 required a molar filling and possible root canal treatment.

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F 157	Continued From page 5 A facility Policy & Procedure Medication Administration And Scheduling dated 9/15, indicated, "The resident and/or legal representative will be notified of new medication orders and the risk/benefit of the medications. All discussions will be documented in the PN (progress note) -Communication with Resident/family." Although F-A was R32's guardian and was to be informed of medical changes the facility failed to inform F-A of a discontinuation of medication namenda and to inform F-A of missed dental and vision appointments.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly resolve complaints and concerns voiced by family members for 1 of 2 residents (R12) reviewed for grievances. Findings include: R12's quarterly Minimum Data Set dated 8/27/15, indicated that she was moderately cognitively impaired and had congestive heart failure (CHF). On 11/3/15, at 1:40 p.m. family (F)-G and (F)-H identified they are the "eyes and ears" for R12	F 166	1) Meeting scheduled for 12/11/2015 at the facility. Members attending this meeting are resident's (R12) family members, MN Regional Ombudsman, and facility staff. Purpose of the meeting is to ensure all family grievances have been responded to, and to develop a plan for ongoing facility-to-family communication. 2) All residents and designated family contacts will receive a mailing by 12/15/15, notifying them of our policy	12/15/15

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F 166	Continued From page 6 and they both and advocate for R12. F-G explained that R12 has had recurrent hospitalization for pulmonary and respiratory issues. F-G stated she had spoken with registered nurse (RN)-A regarding R12's order for Lasix (medication used to treat fluid build-up due to heart failure) when R12's return from hospital stay from 09/30/15-10/02/15. The F-G stated that she was unaware that R12 had not continued the Lasix after she was discharged from the hospital on 09/16/15. During an interview on 11/05/15, at 5:01 p.m. the director of nursing (DON) and administrator both stated they were aware of F-G's concern regarding R12's Lasix. The DON stated she had not followed on the concern expressed by F-G, and was unsure if RN-A had followed with F-G. The administrator stated she also had not spoken to F-G about the Lasix complaint but maybe another facility staff may have spoken to F-G but was unsure. On 11/05/15, at 5:10 p.m. RN-A stated she spoke with F-G on the evening of 10/2/15, about her concerns with R12's Lasix order and hospitalization's. RN-A stated she reviewed the orders and informed the DON of F-G's concerns, and thought the DON and or adminstrator was going to contact the family to follow up on their complaint. Although F-G addressed a concern of R12 not receiving her Lasix and requiring recurrent hospitalizations, the facility did not respond to the family members concerns. A policy was requested and received from facility entitled Grievances, Complaints or Concerns	F 166	regarding Grievances, Complaints or Concerns, along with a copy of a Suggestion/Concern form, and a request to them to please complete the form or contact us if they have any current or unresolved grievances, complaints or concerns. 3) Suggestion/Concern forms are located in the main lobby for any resident or family member to access, 24/7. At every resident care conference, an opportunity will be taken to inquire if there are any concerns. At every resident council meeting, an opportunity will be taken to inquire if there are any concerns. A sample Suggestion/Concern form with directions for completion is located in the main hallway, across from Director of Nursing's office. Re-education will be provided to all staff on GSS policy regarding Grievances, Complaints or Concerns. Any grievance, complaint or concern brought forth will be responded to according to GSS policy and procedure for Grievances, Complaints or Concerns. 4) All Grievances, Complaints or Concerns will be tracked on the Suggestion/Concern form tracking log. QAPI Coordinator/Social Service designee maintains this log and reports to QAPI committee monthly. Audits will be completed monthly x 3 months on all Grievances, Complaints or Concerns to ensure GSS policy and procedure for resolution is followed, with results reported to QAPI committee for further recommendations.	

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F 166	Continued From page 7 dated with revision 08/15. As outlined in Step 1, the Grievance policy is to be utilized as follows: When resident, family member, visitor or staff member expresses a concern or grievance to a staff member related to resident care or services, it will be received in an open, friendly, nonjudgmental manner, without discrimination or reprisal. In Step 5, it identified an investigation must be done for all grievances. In Step 7, if the grievances were not resolved, the administrator would be notified. The policy identified grievances would be resolved within two working days.	F 166		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide dignified dinning for 1 of 1 residents (R23) observed being assisted with eating by staff who stood while feeding her. Findings include: R23's quarterly minimum data set (MDS) dated 8/27/15, indicated the resident had severe cognitive impairment and required total staff assistance with eating. R23's care plan dated 10/12/15, directed staff the	F 241	1) Resident R23 is being provided dignified dining by having staff sit while assisting her. R23's wheelchair was re-evaluated resulting in R23 being placed in smaller-scale, more-appropriate wheelchair on 11/11/2015. 2) All residents who require assistance with eating and drinking will be reviewed by 12/10/15 to ensure they are being provided dignified dining. 3) All nursing and dietary staff will be re-educated on providing dignified dining	12/15/15

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F 241	Continued From page 8 resident required total assistance with eating and drinking. During observation on 11/04/15, at 5:31 p.m. nursing assistant (NA)-K was observed feeding R23 soup, a sandwich, and a beverage. Throughout the constant observation from 5:31 p.m. to 6:10 p.m., NA-K stood while feeding R23. At 5:40 p.m. NA-K walked over to R23's tablemate and stood next to the resident and poured her soup in a cup. NA-K then walked back by R23, and continued to stand while feeding her. During observation on 11/05/15, from 9:00 a.m. to 9:05 a.m. NA-L was observed standing in R23's room and feeding her yogurt. At 9:05 a.m., NA-L tossed the spoon and cup in the garbage, and quickly left R23's room. During interview on 11/05/15, at 10:00 a.m. dietary director (DD) stated staff should be sitting while feeding residents, however, R23 was, "Very large," but staff should be exploring other options such as a different chair for staff to sit on while assisting R23 with eating. The Facility Policy and Procedure dated February 2013, indicated, "The Center will promote care for residents in a manner that maintains or enhances each respites dignity and respect your full recognition of his or her individuality regarding dietary aspects."	F 241	by 12/15/15. 4) Audits of residents who require assistance with eating and drinking will be completed weekly x 4, then monthly x 2, to ensure staff are providing a dignified dining experience, with results reported to QAPI committee for further recommendations.	
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and	F 313		12/15/15

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F 313	Continued From page 9 hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide vision services for 1 of 1 residents (R32) reviewed for vision. Findings include: R32's quarterly minimum data set (MDS) dated 8/19/15, indicated the resident was cognitively intact, and had dementia and schizophrenia. R32's care plan dated 8/13/15, indicated the resident had, "Psychosocial well being problem related to schizophrenia and may believe ideas that she receives are real, or verbalizes, or hallucinates these ideas." R32's medical record contained a notarized document dated and signed 5/01/08, which indicated Guardianship for R32 appointed to family member (F)-A, "Having been appointed Guardian of the above named [R32] ward by the court is qualified and hereby authorized to act as guardian(s) with all the powers and authority prescribed by statute as shown on the order appointing the guardian, the terms of which are incorporated herein by reference including the powers: All of the rights and powers on behalf of the ward under Minn. Stat. 524.5-313 subd. (c)."	F 313	1) Facility staff communicated with Family member (F)-A on 11/11/15 regarding her desire to enroll the resident R32 in new company providing On-Site services. Family member wanted resident enrolled in Podiatry and Hearing, but declined Vision and Dental services, as she will continue to take her out for these services. Resident is currently up-to-date on vision appointments. Resident is next scheduled to see the eye doctor 1 year from last appointment (which would be 07/02/2016). 2) All residents will be reviewed by 12/15/15 to ensure all are current on vision visits as ordered. 3) To ensure all resident vision service needs are met, review and re-education of GSS policy and procedure for providing vision services and offering alternative services if current provider unable to see timely will be provided to facility appointment scheduler and all nurses by 12/15/2015. 4) All ordered vision appointments or	

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F 313	Continued From page 10 During interview 11/3/15, at 6:03 p.m. F-A stated she was responsible for R32's medical decisions and care, and the facility had informed her a eye doctor would come out to the facility to provide a follow up vision appointment for R32. However, that service was not provided and F-A was not notified until the resident began to have problems with her vision, and F-A had to make a eye doctor appointment with an outside clinic. R32's Health and Vision form dated 9/3/14, indicated the resident had seen an eye doctor for open angle glaucoma (complicated disease in which damage to the optic nerve leads to progressive, irreversible vision loss) with borderline intra ocular pressure pseudophakia (a complicated disease in which damage to the optic nerve leads to progressive, irreversible vision loss of both eyes). The document indicated R32 was to return to the eye clinic in 6 months, and was required to check intra ocular pressure every 6 months. R32's facility Progress Note dated 6/2/15, indicated R32 was, "Experiencing complaints of cloudiness and black dot obscuring vision in R (right) eye. Writer faxed communication request for service to in house [eye doctor] to be seen on Friday, 5/29/15. Writer followed up Monday with still no response or indication they would come and see her. Writer LM [left message] with [F-A]. [F-A] called back this morning and stated she would be making an appointment [with eye doctor] to have her seen since we weren't getting anywhere." A clinic referral from the eye doctor dated 6/4/15, indicated R32 now had, "Early macular hole OD (right eye) glaucoma OD>OS (OS left eye)	F 313	follow-up visits will be audited monthly, x 3 months to ensure vision service needs are met. Results reported to QAPI for further recommendations.	

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	245278	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 11 macular degeneration." The Referral indicated date of next appointment to be in one month. R32 was seen again for the follow up appointment at the off site eye doctor on 7/2/15. On 11/5/15, at 3:55 p.m. the facility administrator stated they had a bad experience with In-House vision services and in October 2015, signed a new contract with a new vision service company. The administrator stated they did not show up when they said they would, and it caused a lot of problems for the facility and the residents. Although R32 was seen by the eye doctor on 9/3/14, and was directed to have a follow up appointment in 6 months, the facility did not notify F-A the in house eye doctor was unable to follow up with R32, until the resident began to experience problems with vision, which was almost 9 months later.	F 313		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		12/15/15

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F 329	Continued From page 12 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess and provide medical justification for ongoing use of a medication used for insomnia (inability to sleep) for 1 of 5 residents (R18) reviewed for unnecessary medications. Findings include: R18's quarterly Minimum Data Set (MDS) dated 8/12/15, indicated R18 had no cognitive impairment and had no trouble falling or staying asleep. R18's physician orders dated 11/3/15, indicated an order for, "TraZODone HCL Tablet (antidepressant medication used for insomnia) 100 MG (milligrams) Give 1 tablet by mouth at bedtime related to INSOMNIA." The physician orders identified a start date (date which R18 began to receive the medication) 7/29/14, over one year prior. R18's care plan dated 4/15/14, identified the resident had "increased sleeping," with an intervention to allow R18 to sleep between meals and activities. The care plan did not identify any goals or interventions for R18's sleep despite	F 329	1) Resident R18's Trazodone was reduced in dose and then discontinued as of 11/23/2015. 2) All residents currently on a medication for insomnia will be reviewed by 12/15/15 to ensure appropriate medical justification and monitoring for effectiveness and indications for ongoing use or potential reduction/discontinuation. 3) All nursing staff will be provided with re-education on GSS policy and procedure for monitoring effectiveness and justification for using hypnotic medications. In addition, all residents receiving hypnotic medications will be reviewed monthly by the Pharmacy consultant and Director of Nursing to ensure appropriate medical justification and monitoring for effectiveness and indications for ongoing use or potential reduction/discontinuation. 4) Audits of residents receiving hypnotic medications will be completed weekly x 4 and then monthly x 2 to ensure medical justification and monitoring for ongoing	

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F 329	Continued From page 13 being prescribed Trazodone for insomnia, and being identified as having, "Increased sleeping." R18's Sleep Assessment dated 9/16/14, identified, "Res. (resident) is currently experiencing NO sleep disturbances." R18's medical record lacked any further sleep assessments completed since 9/16/14, or evidence of any assessment completed to determine if R18 still required Trazodone at the current dose. During interview on 11/4/15, at 1:07 p.m. licensed practical nurse (LPN)-A stated R18 was on Trazodone, "to help him sleep." R18's Associated Clinic of Psychology progress notes dated 8/10/15, identified, "No issues with sleep disturbance or mood." Another Associated Clinic of Psychology progress note dated 10/22/15, identified R18, "Denies issues with sleep disturbance, appetite, or mood." R18's Good Samaritan Howard Lake Behavior - Medication Monitoring forms were reviewed and identified the following: On 2/19/15, the pharmacist provided a recommendation which included, "Consider if the Trazodone dose could possibly [be] reduced?" The facility nursing staff identified on the form, "Advise no reductions; Mood anxiety [sic] levels have been unstable." The nursing staff did not identify what, if any, symptoms R18 was experiencing, or any specific rationale why an attempt at reduction could not be attempted. R18's physician response identified, "Agree [with] nursing assessment." The physician did not provide any rationale addressing why a reduction	F 329	use or potential reduction/discontinuation, with results reported to QAPI committee for further recommendations.	

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F 329	Continued From page 14	F 329		

in R18's Trazodone was not be attempted.

On 6/18/15, the pharmacist provided a recommendation which included, "Consider if Trazodone dose could be reduced." The facility nursing staff indicated, "Recent past reductions have led to [increased] mood disturbance and anxiety. Recommend [no] change at this time." The physician provided a response of, "Agree with MED" (minimum effective dose), however, the physician did not provide justification of why a dose reduction was not attempted for the Trazodone in over a year.

On 9/14/15, the pharmacist provided a recommendation which included "Again - consider if Trazodone dose could be reduced." The medical record lacked any documentation this recommendation was followed up on by nursing or the physician.

During interview on 11/05/15, at 1:24 p.m. director of nursing (DON) stated R18 was prescribed Trazodone for insomnia before his admission on 1/3/14, R18's last dose reduction was done in July 2014, and there had been no attempts at dose reduction of the Trazodone since then. The DON stated sleep assessments were completed "PRN" (as needed) for insomnia, and R18's last sleep assessment was completed over a year ago.

Although R18 continued on Trazodone for insomnia without any justification for not attempting a dose decrease recommended by the pharmacist on 2/19/15, 6/18/15, and 9/14/15, the facility had not reassessed R18's sleep to determine the resident was receiving the appropriate dose and continued to require the

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F 329	Continued From page 15 medication for insomnia. A facility Psychopharmacological Medications and Sedative/Hypnotics policy dated 8/14, indicated, "Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs." A facility Psychopharmacological Medications and Sedative/Hypnotics procedure dated 3/15, indicated, "For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the center should attempt to taper the medication quarterly unless clinically contraindicated."	F 329		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure dental service were provided for 1 of 3 residents (R32) reviewed for dental services.	F 412	1) Facility staff communicated with Family member (F)-A on 11/11/15 regarding her desire to enroll the resident R32 in new company providing On-Site	12/15/15

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F 412	Continued From page 16 Findings include: R32's quarterly minimum data set (MDS) dated 8/19/15, indicated the resident was cognitively intact, and had dementia and schizophrenia. During interview 11/3/15, at 6:03 p.m. family (F)-A stated she was the guardian for R32's medical decisions, and the facility had informed F-A a dentist would come out to the facility and provide dental services, however, the service was not provided and she was not made aware timely so she could ensure R32 had dental follow up within the 6 months as had been directed at the residents last dental visit. R32's medical record indicated a referral was completed on 7/14/14, and she was seen by a DDS (doctor of dental surgery) and the referral indicated, "Pt (patient) has upper and lower partial dentures that fit well. Pt has no concerns at this time. No decay noted. Existing restorations are in good condition." The Referral directed R32 was to return for a follow up visit in 6 months. The facility sent an e-mail to the in house dentist on 4/04/15, (nine months later) indicating R32 had a previous recommendation to have a follow up dental appointment. The response email from the in house dental clinic indicated the family would have to pay $119 in between the yearly visits since (MA) medical assistance would not cover the visit. R32 was not seen again by a dentist until 9/24/15, 14 months after the initial dental appointment. The follow up dental appointment on 9/24/15, indicated R32 required a molar filling and possible root canal treatment. During interview on 11/5/15, at 3:55 p.m. the facility administrator stated the facility had a bad experience with in-House dental services not	F 412	services. Family member wanted resident enrolled in Podiatry and Hearing, but declined Vision and Dental services, as she will continue to take her out for these services. Care conference held on 11/19/2015, with Family member (F)-A present via phone. Family member stated she sent the paperwork to Centra Sota Oral Surgeons and they should be contacting the facility for medical records. 2) All residents will be reviewed by 12/15/15 to ensure all are current on dental visits as ordered. 3) To ensure all resident dental service needs are met, review and re-education of GSS policy and procedure for providing dental services and offering alternative services if current provider unable to see timely will be provided to facility appointment scheduler and all nurses by 12/15/2015. 4) All ordered dental appointments or follow-up visits will be audited monthly, x 3 months to ensure dental service needs are met. Results will be reported to QAPI for further recommendations.	

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F 412	Continued From page 17 showing up for appointments when they said they would, and in October 2015, they had signed a new contract with a new dental company to provide resident dental care at the facility. Although the dental record's indicated R32 was to have a follow up visit in 6 months, she was not seen until 14 months later.	F 412		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 21, 2014. At the time of this survey, Good Samaritan Society Howard Lake was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

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

Electronically Signed | 11/30/2015

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.

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society Howard Lake is a one-story building with no basement. The original building was constructed in 1971, with building additions constructed in 1983 and 1994. All buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 26 at time of the survey.	K 000		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		12/15/15

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K 062 SS=F	Continued From page 2 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire sprinkler system in accordance with the provisions at NFPA 101 (2000) Chapter 19 and NFPA 13 (1999). In a fire emergency, this deficient practice could adversely affect 50 of 50 residents, staff and visitors. FINDINGS INCLUDE: On facility tour between 9:30 am and 12:00 PM on 11/03/2015, it was observed the water pressure gauge on the fire sprinkler system riser was not marked with a date. In a subsequent interview with facility staff, no documentation could be provided verifying the fire sprinkler system gauge had been recalibrated or replaced within the previous five (5) years. This deficient practice was not in accordance with the requirements at NFPA 25 (1998 edition) Chapter 2, Section 2-3.2. This deficient practice was verified by Enviromental Services Director (CZ)	K 062	1. The water pressure gauge on the fire sprinkler system riser will be replaced and dated as required. Proper documentation will be acquired and maintained as required per the Life Safety Code. 2. This will be completed by 12/15/15. 3. The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		11/4/15

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Generators must be inspected weekly and exercised under load at not less than 30% of the EPS nameplate rating, for 30 minutes per month and shall be in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). This STANDARD is not met as evidenced by: Based upon a staff interview and review of available records, the facility did not perform weekly inspections from 08/24/2015- 10/07/2015 for the emergency generator. In a fire or other emergency, this deficient practice could adversely affect all residents, staff and visitors. This deficient practice was verified by Enviromental Services Director (CZ)	K 144	1. Weekly, monthly and annual inspection, testing and documentation of the Emergency Generator will occur as required per the Life Safety Code. 2. Testing and proper documentation have continuously occurred with the exception of a missed 3 week period from 9/6/15 – 9/26/15. This will not be overlooked again. 3. The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition.	K 147	1. The appliance that was plugged into a power strip is now plugged directly into a wall outlet as required per the Life Safety	11/4/15

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K 147	Continued From page 4 section 9.1.2. This deficiency could negatively effect the 5 of 26 residents. Findings include: On facility tour between 9:30 am and 12:00 PM on 11/03/2015, it was observed: 1. The washing machine was plugged into a power strip in the laundry room. This deficient practice was verified by Enviromental Services Director (CZ)	K 147	Code. 2. This was completed on 11/04/15. 3. The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
November 20, 2015

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5278023 & Complaint Number H5278005

Dear Ms. Salonek:

The above facility was surveyed on November 2, 2015 through November 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5278005. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary

Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00019	A. BUILDING: _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	On November 2-5th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. In addition, an investigation of complaint H5360015 was completed. The complaint was substantiated. Correction orders were	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 2-5, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. A compliant investigation was also completed for complaint H5278005 and was substantiated. Licensing orders were issued as a result of the complaint. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE	2 000	issued at State Licensing Statute #4658.0085 A-E 0265 and Statute 4658.1320 Subp. B 1545. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St. Cloud, MN 56301.	

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		12/15/15

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the residents legal guardian, family member (F)-A, with medication changes, and missed dental and vision visits for 1 of 1 residents (R32), who had a legal guardian. Findings include: R32's quarterly minimum data set (MDS) dated 8/19/15, indicated the resident was cognitively intact, and had dementia and schizophrenia. R32's care plan dated 8/13/15, indicated the resident had, "Psychosocial well being problem related to schizophrenia and may believe ideas that she receives are real, or verbalizes, or hallucinates these ideas." R32's medical record contained a notarized document dated and signed 5/01/08, which indicated Guardianship for R32 appointed to family member (FM)-A, "Having been appointed Guardian of the above named [R32] ward by the court is qualified and hereby authorized to act as guardian(s) with all the powers and authority prescribed by statute as shown on the order appointing the guardian, the terms of which are incorporated herein by reference including the powers: All of the rights and powers on behalf of the ward under Minn. Stat. 524.5-313 subd. (c)."	2 265	Corrected	

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2 265	Continued From page 4 During interview 11/3/15, at 6:03 p.m. F-A stated she was the guardian for R32's medical decisions, and the facility had discontinued R32's namenda (medication to treat dementia related to Alzheimer's disease) with out her consent or input. F-A stated she did not realize the medication was stopped until R32 went to see her neurologist/psychiatric doctor and they did not want her taken off the namenda. The facility had also informed F-A a dental company would come out to the facility and provide dental and vision services for R32, however, neither services were provided and she was not informed. F-A stated she felt as R32's legal guardian, she should be made aware of all changes. A Chemical Restraint/Behavior Committee form dated 4/9/15, indicated R32 was receiving namenda 10 mg (milligrams) orally, twice a day. The form was sent to R32's primary physician by the facility requesting, "May we try reduction as side effects of medication side effects potentially outweighs benefit. Will monitor for increased symptoms of dementia and decrease in cognition." The physician responded on 4/15/15, to decrease Namenda to 5 mg in the a.m., and 10 mg in the p.m. An additional request was sent to R32's primary physician by the facility on 6/22/15, which indicated, "May we d/c (discontinue) Namenda. Past reduction has gone well." The physician responded on 6/29/15, to discontinue namenda. A Clinic Referral form for R32 dated 8/7/15, indicated the resident had been seen by her neurologist/psychiatric doctor and was ordered R32 to restart namenda 10 mg twice a day. During interview 11/04/15, at 12:36 p.m. with the	2 265		

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2 265	Continued From page 5	2 265		

director of nursing (DON) who stated she was not aware that FM-A was R32's guardian. The DON stated she did not inform R32's F-A of the medication changes and should have since she is the guardian.

R32's Health and Vision form dated 9/3/14, indicated the resident had seen an eye doctor for open angle glaucoma (complicated disease in which damage to the optic nerve leads to progressive, irreversible vision loss) with borderline intra ocular pressure pseudophakia (a complicated disease in which damage to the optic nerve leads to progressive, irreversible vision loss of both eyes). The document indicated R32 was to return to the eye clinic in 6 months, and was required to check intra ocular pressure every 6 months.
R32's facility Progress Note dated 6/2/15, indicated R32 was, "Experiencing complaints of cloudiness and black dot obscuring vision in R (right) eye. Writer faxed communication request for service to in house [eye doctor] to be seen on Friday, 5/29/15. Writer followed up Monday with still no response or indication they would come and see her. Writer LM [left message] with [F-A]. [F-A] called back this morning and stated she would be making an appointment [with eye doctor] to have her seen since we weren't getting anywhere. Daughter also expressed concern about residents dental care."
A clinic referral from the eye doctor dated 6/4/15, indicated R32 now had, "Early macular hole OD (right eye) glaucoma OD>OS (OS left eye) macular degeneration." The Referral indicated date of next appointment to be in one month.
R32 was seen for the follow up appointment at the off site eye doctor on 7/2/15.
Although R32 was seen by the eye doctor on 9/3/14, and was directed to have a follow up

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2 265	Continued From page 6	2 265		

appointment in 6 months, the facility did not initiate a follow up appointment, nor notify FM-A the in house eye doctor was unable to follow up with R32, until the resident began to experience problems with vision, which was almost 9 months later.
R32's medical record indicated a dental referral was completed on 7/14/14, and she was seen by a DDS (doctor of dental surgery) and the referral indicated, "Pt (patient) has upper and lower partial dentures that fit well. Pt has no concerns at this time. No decay noted. Existing restorations are in good condition." The Referral directed R32 was to return for a follow up visit in 6 months. The facility sent an e-mail to the in house dentist on 4/04/15, (nine months later) indicating R32 had a previous recommendation to have a follow up dental appointment. The response email from the in house dental clinic indicated the family would have to pay $119 in between the yearly visits since (MA) medical assistance would not cover the visit. R32 was not seen again by a dentist until 9/24/15, 14 months after the initial dental appointment. The follow up dental appointment on 9/24/15, indicated R32 required a molar filling and possible root canal treatment.
A facility Policy & Procedure Medication Administration And Scheduling dated 9/15, indicated, "The resident and/or legal representative will be notified of new medication orders and the risk/benefit of the medications. All discussions will be documented in the PN (progress note) -Communication with Resident/family."

Although F-A was R32's guardian and was to be informed of medical changes the facility failed to inform F-A of a discontinuation of medication namenda and to inform F-A of missed dental and

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2 265	Continued From page 7 vision appointments. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could inservice staff regarding notifying the residents responsible party with treatment changes and audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure dental service were provided for 1 of 3 residents (R32) reviewed for dental services. Findings include: R32's quarterly minimum data set (MDS) dated 8/19/15, indicated the resident was cognitively intact, and had dementia and schizophrenia. During interview 11/3/15, at 6:03 p.m. family (F)-A stated she was the guardian for R32's medical	21325	corrected	12/15/15

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21325	Continued From page 8	21325		

decisions, and the facility had informed F-A a dentist would come out to the facility and provide dental services, however, the service was not provided and she was not made aware timely so she could ensure R32 had dental follow up within the 6 months as had been directed at the residents last dental visit.

R32's medical record indicated a referral was completed on 7/14/14, and she was seen by a DDS (doctor of dental surgery) and the referral indicated, "Pt (patient) has upper and lower partial dentures that fit well. Pt has no concerns at this time. No decay noted. Existing restorations are in good condition." The Referral directed R32 was to return for a follow up visit in 6 months.
The facility sent an e-mail to the in house dentist on 4/04/15, (nine months later) indicating R32 had a previous recommendation to have a follow up dental appointment. The response email from the in house dental clinic indicated the family would have to pay $119 in between the yearly visits since (MA) medical assistance would not cover the visit. R32 was not seen again by a dentist until 9/24/15, 14 months after the initial dental appointment. The follow up dental appointment on 9/24/15, indicated R32 required a molar filling and possible root canal treatment.
During interview on 11/5/15, at 3:55 p.m. the facility administrator stated the facility had a bad experience with in-House dental services not showing up for appointments when they said they would, and in October 2015, they had signed a new contract with a new dental company to provide resident dental care at the facility.
Although the dental record's indicated R32 was to have a follow up visit in 6 months, she was not seen until 14 months later.

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21325	Continued From page 9 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to providing timely dental services. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21325		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.	21535		12/15/15

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21535	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess and provide medical justification for ongoing use of a medication used for insomnia (inability to sleep) for 1 of 5 residents (R18) reviewed for unnecessary medications. Findings include: R18's quarterly Minimum Data Set (MDS) dated 8/12/15, indicated R18 had no cognitive impairment and had no trouble falling or staying asleep. R18's physician orders dated 11/3/15, indicated an order for, "TraZODone HCL Tablet (antidepressant medication used for insomnia) 100 MG (milligrams) Give 1 tablet by mouth at bedtime related to INSOMNIA." The physician orders identified a start date (date which R18 began to receive the medication) 7/29/14, over one year prior. R18's care plan dated 4/15/14, identified the resident had "increased sleeping," with an intervention to allow R18 to sleep between meals and activities. The care plan did not identify any goals or interventions for R18's sleep despite being prescribed Trazodone for insomnia, and being identified as having, "Increased sleeping." R18's Sleep Assessment dated 9/16/14, identified, "Res. (resident) is currently experiencing NO sleep disturbances." R18's medical record lacked any further sleep assessments completed since 9/16/14, or evidence of any assessment completed to	21535	corrected	

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21535	Continued From page 11 determine if R18 still required Trazodone at the current dose. During interview on 11/4/15, at 1:07 p.m. licensed practical nurse (LPN)-A stated R18 was on Trazodone, "to help him sleep." R18's Associated Clinic of Psychology progress notes dated 8/10/15, identified, "No issues with sleep disturbance or mood." Another Associated Clinic of Psychology progress note dated 10/22/15, identified R18, "Denies issues with sleep disturbance, appetite, or mood." R18's Good Samaritan Howard Lake Behavior - Medication Monitoring forms were reviewed and identified the following: On 2/19/15, the pharmacist provided a recommendation which included, "Consider if the Trazodone dose could possibly [be] reduced?" The facility nursing staff identified on the form, "Advise no reductions; Mood anxiety [sic] levels have been unstable." The nursing staff did not identify what, if any, symptoms R18 was experiencing, or any specific rationale why an attempt at reduction could not be attempted. R18's physician response identified, "Agree [with] nursing assessment." The physician did not provide any rationale addressing why a reduction in R18's Trazodone was not be attempted. On 6/18/15, the pharmacist provided a recommendation which included, "Consider if Trazodone dose could be reduced." The facility nursing staff indicated, "Recent past reductions have led to [increased] mood disturbance and anxiety. Recommend [no] change at this time." The physician provided a response of, "Agree with MED" (minimum effective dose), however,	21535		

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21535	Continued From page 12	21535		

the physician did not provide justification of why a dose reduction was not attempted for the Trazodone in over a year.

On 9/14/15, the pharmacist provided a recommendation which included "Again - consider if Trazodone dose could be reduced." The medical record lacked any documentation this recommendation was followed up on by nursing or the physician.

During interview on 11/05/15, at 1:24 p.m. director of nursing (DON) stated R18 was prescribed Trazodone for insomnia before his admission on 1/3/14, R18's last dose reduction was done in July 2014, and there had been no attempts at dose reduction of the Trazodone since then. The DON stated sleep assessments were completed "PRN" (as needed) for insomnia, and R18's last sleep assessment was completed over a year ago.

Although R18 continued on Trazodone for insomnia without any justification for not attempting a dose decrease recommended by the pharmacist on 2/19/15, 6/18/15, and 9/14/15, the facility had not reassessed R18's sleep to determine the resident was receiving the appropriate dose and continued to require the medication for insomnia.

A facility Psychopharmacological Medications and Sedative/Hypnotics policy dated 8/14, indicated, "Residents who use antipsychotic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs."

A facility Psychopharmacological Medications and Sedative/Hypnotics procedure dated 3/15,

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21535	Continued From page 13 indicated, "For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the center should attempt to taper the medication quarterly unless clinically contraindicated." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to unnecessary medications/ parameters for use. Responsible personnel could be re-educated on these policies and procedures. The medication regimen for the individual(s) identified in the deficiency could be reviewed for compliance with these policies, with appropriate actions taken when necessary. Supporting documentation could be maintained. The medication regimens of other residents could be evaluated for lacking parameters, with appropriate efforts made toward compliance. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		12/15/15

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21805	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide dignified dinning for 1 of 1 residents (R23) observed being assisted with eating by staff who stood while feeding her. Findings include: R23's quarterly minimum data set (MDS) dated 8/27/15, indicated the resident had severe cognitive impairment and required total staff assistance with eating. R23's care plan dated 10/12/15, directed staff the resident required total assistance with eating and drinking. During observation on 11/04/15, at 5:31 p.m. nursing assistant (NA)-K was observed feeding R23 soup, a sandwich, and a beverage. Throughout the constant observation from 5:31 p.m. to 6:10 p.m., NA-K stood while feeding R23. At 5:40 p.m. NA-K walked over to R23's tablemate and stood next to the resident and poured her soup in a cup. NA-K then walked back by R23, and continued to stand while feeding her. During observation on 11/05/15, from 9:00 a.m. to 9:05 a.m. NA-L was observed standing in R23's room and feeding her yogurt. At 9:05 a.m., NA-L tossed the spoon and cup in the garbage, and quickly left R23's room. During interview on 11/05/15, at 10:00 a.m. dietary director (DD) stated staff should be sitting while feeding residents, however, R23 was, "Very large," but staff should be exploring other options	21805	corrected	

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21805	Continued From page 15 such as a different chair for staff to sit on while assisting R23 with eating. The Facility Policy and Procedure dated February 2013, indicated, "The Center will promote care for residents in a manner that maintains or enhances each respites dignity and respect your full recognition of his or her individuality regarding dietary aspects." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to dignified dinning services. Responsible personnel could be re-educated on these policies and procedures. Care practices for the individual(s) identified in the defliciency could be reviewed and/or revised for compliance with these policies, with supporting documentation maintained. Other residents could be evaluated for dignified care and services. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21805		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend	21880		12/15/15

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21880	Continued From page 16 changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21880	corrected	

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21880	Continued From page 17 facility failed to promptly resolve complaints and concerns voiced by family members for 1 of 2 residents (R12) reviewed for grievances. Findings include: R12's quarterly Minimum Data Set dated 8/27/15, indicated that she was moderately cognitively impaired and had congestive heart failure (CHF). On 11/3/15, at 1:40 p.m. family (F)-G and (F)-H identified they are the "eyes and ears" for R12 and they both and advocate for R12. F-G explained that R12 has had recurrent hospitalization for pulmonary and respiratory issues. F-G stated she had spoken with registered nurse (RN)-A regarding R12's order for Lasix (medication used to treat fluid build-up due to heart failure) when R12's return from hospital stay from 09/30/15-10/02/15. The F-G stated that she was unaware that R12 had not continued the Lasix after she was discharged from the hospital on 09/16/15. During an interview on 11/05/15, at 5:01 p.m. the director of nursing (DON) and administrator both stated they were aware of F-G's concern regarding R12's Lasix. The DON stated she had not followed on the concern expressed by F-G, and was unsure if RN-A had followed with F-G. The administrator stated she also had not spoken to F-G about the Lasix complaint but maybe another facility staff may have spoken to F-G but was unsure. On 11/05/15, at 5:10 p.m. RN-A stated she spoke with F-G on the evening of 10/2/15, about her concerns with R12's Lasix order and hospitalization's. RN-A stated she reviewed the orders and informed the DON of F-G's concerns,	21880		

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21880	Continued From page 18 and thought the DON and or adminstrator was going to contact the family to follow up on their complaint. Although F-G addressed a concern of R12 not receiving her Lasix and requiring recurrent hospitalizations, the facility did not respond to the family members concerns. A policy was requested and received from facility entitled Grievances, Complaints or Concerns dated with revision 08/15. As outlined in Step 1, the Grievance policy is to be utilized as follows: When resident, family member, visitor or staff member expresses a concern or grievance to a staff member related to resident care or services, it will be received in an open, friendly, nonjudgmental manner, without discrimination or reprisal. In Step 5, it identified an investigation must be done for all grievances. In Step 7, if the grievances were not resolved, the administrator would be notified. The policy identified grievances would be resolved within two working days. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and/or revise facility policies and procedures related to individual resident grievances. Responsible personnel could be re-educated on these policies and procedures. Grievances could be addressed for the individual(s) identified in the deficiency, with supporting documentation maintained. Other residents could be evaluated for appropriate response to voiced grievances. An auditing system could be developed and implemented, with results shared with the facility's Quality Assessment & Assurance committee, to ensure on-going compliance.	21880		

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21880	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		