#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: F5CI

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

|  | PART  | I - TO BE COM  | PLETED BY 1                            | THE STAT                      | E SURVEY AC   | GENCY  | F   | acility ID: 00019                              |  |
|--|---|--|--|-------------------------------|---|--|---|--|--|
| 1. MEDICARE/MEDICAID PROVIDER N<br>(L1) 245278<br>2.STATE VENDOR OR MEDICAID NO.<br>(L2) 608716700   | 0.  | 3. NAME AND ADI<br>(L3) <b>GOOD SAM</b> .<br>(L4) <b>413 13TH AV</b><br>(L5) <b>HOWARD L</b> .                       | ARITAN SOCIE<br>VENUE                  |                               |   | 55349  | 4. TYPE OF ACTION:  1. Initial 3. Termination 5. Validation | 7 (L8) 2. Recertification 4. CHOW 6. Complaint |  |
| 5. EFFECTIVE DATE CHANGE OF OWN (L9)   | NERSHIP   | 7. PROVIDER/SUF  | PPLIER CATEGOR                         | RY<br>09 ESRD                 | <u>02</u> (L7   | )<br>22 CLIA   | 7. On-Site Visit  8. Full Survey After Co                   | 9. Other<br>mplaint                            |  |
| 6. DATE OF SURVEY 01/04/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other                 | / <b>2016</b> (L34)<br>(L10)  | 02 SNF/NF/Dual<br>03 SNF/NF/Distinct<br>04 SNF   | 06 PRTF<br>07 X-Ray<br>08 OPT/SP       | 10 NF<br>11 ICF/IID<br>12 RHC | 14 CORF<br>15 ASC<br>16 HOSPICE   |  | FISCAL YEAR ENDING 09/30                                    | DATE: (L35)                                    |  |
| 11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds | 35 (L18)<br>35 (L17)  | 10.THE FACILITY IS CERTIFIED AS:  X A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC |  |                               | hnical Personnel<br>Hour RN<br>ay RN (Rural SNF)<br>e Safety Code   | 6. Scope of Servi 7. Medical Direct 8. Patient Room S 9. Beds/Room | or  |  |  |
| 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 35  | 19 SNF  | ICF  | IID                                    |                               | 15. FACILITY M  |  | (L15)   |  |  |
| (L37) (L38)  16. STATE SURVEY AGENCY REMARK  | (L37) (L38) (L39) (L42) (L43)  5. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): |  |  |                               |   |  |   |  |  |
| 17. SURVEYOR SIGNATURE   | 7. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date:  |  |  |                               |   |  |   |  |  |
| Brenda Fischer, U  | nit Superviso   | or (   | 01/04/2016                             | (L19)                         | Kate JohnsTon, Program Specialist 01/05/2016 (L20)  |  |   |  |  |
|  | PART II - TO  | BE COMPLETE  | D BY HCFA R                            | EGIONAL                       | OFFICE OR   | SINGLE STAT  | E AGENCY  |  |  |
| DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Part  2. Facility is not Eligible        |   |  | IPLIANCE WITH O                        | CIVIL                         | <ul> <li>21. I. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ul> |  |   |  |  |
| 2. I defintly is not Engine  | (L21)   |  |  |                               |   |  |   |  |  |
| 22. ORIGINAL DATE  OF PARTICIPATION  04/01/1985  (L24)   | 23. LTC AGREEMI<br>BEGINNING (L41)  |  | 24. LTC AGREEMI<br>ENDING DAT<br>(L25) |                               | VOLUNTARY<br>01-Merger, Closs   | TION ACTION:  00  ure  on W/ Reimbursemer                          | INVOLUNT<br>05-Fail to Mo                                   | L30)  ARY  eet Health/Safety  eet Agreement    |  |
| 25. LTC EXTENSION DATE: (L27)  | 27. ALTERNATIVI A. Suspension of B. Rescind Sus   | of Admissions:   | (L44)                                  |                               | 03-Risk of Involu<br>04-Other Reason  | ntary Termination<br>for Withdrawal                                | OTHER<br>07-Provider<br>00-Active                           | Status Change                                  |  |
| 28. TERMINATION DATE:  | 20  | . INTERMEDIARY/C   | (L45)                                  |                               | 30. REMARKS   |  |   |  |  |
| 26. TERMINATION DATE.  | 29  | 00140  | ARRIER NO.                             |                               | 30. KEWAKKS   |  |   |  |  |
|  | (L28)   | 00140  |  | (L31)                         |   |  |   |  |  |
| 31. RO RECEIPT OF CMS-1539   | 32  | . DETERMINATION C  | OF APPROVAL DA                         | ATE .                         | Posted 01/2   | 6/2016 Co.   |   |  |  |
|  | (L32)   | 12/09/2015   |  | (L33)                         | DETERMINA   | ATION APPRO  | VAL   |  |  |



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.

Good Samaritan Society - Howard Lake January 5, 2016 Page 2

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



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

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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

| (Y1)                                 | Provider / Supplier / CLIA /<br>Identification Number<br>245278 | (Y2) Multiple Construction A. Building B. Wing | A. Building                              |  |  |  |  |
|--------------------------------------|---|--|--|--|--|--|--|
| Name                                 | Name of Facility  |  | Street Address, City, State, Zip Code    |  |  |  |  |
| GOOD SAMARITAN SOCIETY - HOWARD LAKE |   | AKE  | 413 13TH AVENUE<br>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                        |
|---------------|---------------------|--------|-------------------------|------|---------------|--------------|--------|-----------------------------|-----|----------------|------------------|-------|-----------------------------|
|               |                     |        | Correction<br>Completed |      |               |              |        | Correction<br>Completed     |     |                |                  |       | Correction<br>Completed     |
| ID Prefix     | F0157               |        | 12/15/2015              |      | ID Prefix     | F0166        |        | 12/15/2015                  |     | ID Prefix      | F0241            |       | 12/15/2015                  |
| •             | 483.10(b)(11)       |        |                         |      | •             | 483.10(f)(2) |        |                             |     |                | 483.15(a)        |       | _                           |
| LSC           |                     |        |                         |      | LSC           |              |        |                             |     | LSC            |                  |       |                             |
|               |                     |        | Correction              |      |               |              |        | Correction                  |     |                |                  |       | Correction                  |
| ID Prefix     | E0313               |        | Completed<br>12/15/2015 |      | ID Prefix     | E0330        |        | Completed <b>12/15/2015</b> |     | ID Prefix      | E0412            |       | Completed <b>12/15/2015</b> |
|               |                     |        | 12/13/2013              |      |               |              |        | 12/13/2013                  |     |                |                  |       |                             |
|               | 483.25(b)           |        |                         |      | LSC           | 483.25(I)    |        |                             |     |                | 483.55(b)        |       | _                           |
|               |                     |        |                         | -    |               |              |        |                             | +   |                |                  |       |                             |
|               |                     |        | Correction              |      |               |              |        | Correction                  |     |                |                  |       | Correction                  |
|               |                     |        | Completed               |      |               |              |        | Completed                   |     |                |                  |       | Completed                   |
| ID Prefix     |                     |        |                         |      | ID Prefix     |              |        | -                           |     | ID Prefix      |                  |       | _                           |
| Reg. #<br>LSC |                     |        |                         |      | Reg. #<br>LSC |              |        |                             |     | Reg. #         |                  |       | _                           |
|               |                     |        |                         | _    | Loc           |              |        |                             | -   |                |                  |       | _                           |
|               |                     |        | Correction              |      |               |              |        | Correction                  |     |                |                  |       | Correction                  |
|               |                     |        | Completed               |      |               |              |        | Completed                   |     |                |                  |       | Completed                   |
| ID Prefix     |                     |        |                         |      | ID Prefix     |              |        |                             |     | ID Prefix      |                  |       | _                           |
| Reg. #        |                     |        |                         |      | Reg. #        |              |        |                             |     | Reg. #         |                  |       | _                           |
| LSC           |                     |        |                         |      | LSC           |              |        |                             |     | LSC            |                  |       |                             |
|               |                     |        | Correction              |      |               |              |        | Correction                  |     |                |                  |       | Correction                  |
|               |                     |        | Completed               |      |               |              |        | Completed                   |     |                |                  |       | Completed                   |
| ID Prefix     |                     |        | •                       |      | ID Prefix     |              |        |                             |     | ID Prefix      |                  |       | _                           |
| Reg. #        |                     |        |                         |      | Reg.#         |              |        |                             |     | Reg. #         |                  |       | _                           |
| LSC           |                     |        |                         |      | LSC           |              |        |                             |     | LSC            |                  |       | _                           |
|               |                     |        |                         |      |               |              |        |                             |     |                |                  |       |                             |
| Reviewed By   | Revie               | ewed B | у                       | Da   | te:           | Signature of | Surve  | yor:                        |     |                |                  | Date: |                             |
| State Agency  | ,                   | В      | F/KJ                    | 1/.  | 5/2016        |              |        | 28598                       |     |                |                  | 1/4/2 | 2016                        |
| Reviewed By   | Revie               | ewed B | у                       | Dat  | te:           | Signature of | Surve  | yor:                        |     |                |                  | Date: |                             |
| CMS RO        |                     |        |                         |      |               |              |        |                             |     |                |                  |       |                             |
| Followup to   | Survey Completed or | n:     |                         |      |               |              | -      |                             |     |                | a Summary of     |       |                             |
|               | 11/5/2015           |        |                         |      |               | Unco         | rrecte | d Deficiencies              | (CI | /IS-2567) Sent | to the Facility? | YES   | NO                          |

Form Approved OMB NO. 0938-0390

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| (Y1)                                 | Provider / Supplier / CLIA /<br>Identification Number<br>245278 | (Y2) Multiple Construction A. Building B. Wing | A. Building                              |  |  |  |  |
|--------------------------------------|---|--|--|--|--|--|--|
| Name of Facility                     |   |  | Street Address, City, State, Zip Code    |  |  |  |  |
| GOOD SAMARITAN SOCIETY - HOWARD LAKE |   | _AKE   | 413 13TH AVENUE<br>HOWARD LAKE, MN 55349 |  |  |  |  |

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| (Y4) Item     |                    | (Y5)  | Date                    | (Y4) | Item          |              | (Y5)  | Date                    | (Y4 | ) Item        |              | (Y5)  | Date                    |
|---------------|--------------------|---|-------------------------|------|---------------|--------------|-------|-------------------------|-----|---------------|--------------|-------|-------------------------|
|               |                    |   | Correction<br>Completed |      |               |              |       | Correction<br>Completed |     |               |              |       | Correction<br>Completed |
| ID Prefix     | F0157              |   | 12/15/2015              |      | ID Prefix     | F0313        |       | 12/15/2015              |     | ID Prefix     | F0412        |       | 12/15/2015              |
| ŭ             | 483.10(b)(11)      |   |                         |      | •             | 483.25(b)    |       |                         |     | Reg. #<br>LSC | 483.55(b)    |       | _                       |
| LSC           |                    |   |                         |      | LSC           |              |       |                         | _   |               |              |       | _                       |
|               |                    |   | Correction              |      |               |              |       | Correction              |     |               |              |       | Correction              |
|               |                    |   | Completed               |      |               |              |       | Completed               |     |               |              |       | Completed               |
| ID Prefix     |                    |   | ·                       |      | ID Prefix     |              |       |                         |     | ID Prefix     | -            |       | _                       |
| Reg. #        |                    |   |                         |      | Reg. #        |              |       |                         |     | Reg. #        |              |       | _                       |
| LSC           |                    |   |                         |      | LSC           |              |       |                         |     | LSC           |              |       |                         |
|               |                    |   |                         |      |               |              |       |                         |     |               |              |       |                         |
|               |                    |   | Correction              |      |               |              |       | Correction              |     |               |              |       | Correction              |
| ID Prefix     |                    | ,   | Completed               |      | ID Prefix     |              |       | Completed               |     | ID Prefix     |              |       | Completed               |
| Reg. #        |                    |   |                         |      | Reg. #        |              |       |                         |     | Reg. #        |              |       |                         |
| LSC           |                    |   |                         |      | LSC           |              |       |                         |     | LSC           |              |       | _                       |
|               |                    |   |                         |      |               |              |       |                         | T   |               |              |       |                         |
|               |                    | (   | Correction              |      |               |              |       | Correction              |     |               |              |       | Correction              |
| ID Prefix     |                    |   | Completed               |      | ID Prefix     |              |       | Completed               |     | ID Prefix     |              |       | Completed               |
|               |                    |   |                         |      | Reg. #        |              |       |                         |     |               |              |       | _                       |
| Reg. #<br>LSC |                    |   |                         |      |               |              |       |                         |     | LSC           |              |       | _                       |
|               |                    |   |                         |      |               |              |       |                         | +   |               |              |       | _                       |
|               |                    | (   | Correction              |      |               |              |       | Correction              |     |               |              |       | Correction              |
| 10.0 %        |                    |   | Completed               |      | 10.0.6        |              |       | Completed               |     | ID D . C      |              |       | Completed               |
|               |                    |   |                         |      |               |              |       |                         |     |               |              |       | _                       |
| Reg. #<br>LSC |                    |   |                         |      | Reg. #<br>LSC |              |       |                         |     | Reg. #        |              |       | _                       |
|               |                    |   |                         |      | 130           |              |       |                         | +   |               |              |       | _                       |
|               |                    |   |                         |      |               |              |       |                         |     |               |              |       |                         |
| Reviewed By   | Revie              | ewed B  | у                       | Da   | te:           | Signature of | Surve | yor:                    |     |               |              | Date: |                         |
| State Agency  | ,                  | BF  | F/KJ                    | 1/5  | 5/2016        |              |       | 10562                   | 2   |               |              | 1/4/2 | 016                     |
| Reviewed By   | Revie              | ewed B  | у                       | Da   | te:           | Signature of | Surve | yor:                    |     |               |              | Date: |                         |
| CMS RO        |                    |   |                         |      |               |              |       |                         |     |               |              |       |                         |
| Followup to   | Survey Completed o | n:  |                         |      |               |              | -     |                         |     |               | a Summary of | ·     |                         |
| 11/5/2015     |                    | Uncorrected Deficiencies (CMS-2567) Sent to the Facility? |                         |      |               |              |       | YES                     | NO  |               |              |       |                         |

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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| (Y1) Provider / Supplier / CLIA /<br>Identification Number<br>245278 | (Y2) Multiple Constru<br>A. Building<br>B. Wing | N BUILDING 01                            | (Y3) Date of Revisit<br>12/18/2015 |
|--|---|--|------------------------------------|
| Name of Facility   |   | Street Address, City, State, Zip Code    |                                    |
| GOOD SAMARITAN SOCIETY - HOWARD                                      | LAKE  | 413 13TH AVENUE<br>HOWARD LAKE, MN 55349 |                                    |

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| (Y4) Item    |                    | (Y5)   | Date                 | (Y4) | Item      |                   | (Y5)  | Date                 | (Y4   | ) Item       |                   | (Y5)  | Date                    |
|--------------|--------------------|--------|----------------------|------|-----------|-------------------|-------|----------------------|-------|--------------|-------------------|-------|-------------------------|
|              |                    |        | Correction           |      |           |                   |       | Correction           |       |              |                   |       | Correction              |
| ID Deefin    |                    |        | Completed            |      | ID Deafin |                   |       | Completed            |       | ID Danfin    |                   |       | Completed               |
| ID Prefix    |                    |        | 12/15/2015           |      |           |                   |       | 11/04/2015           |       |              |                   |       | 11/04/2015              |
| •            | NFPA 101<br>K0062  |        |                      |      | -         | NFPA 101<br>K0144 |       |                      |       | •            | NFPA 101<br>K0147 |       | _                       |
|              | K0002              |        |                      | -    |           | K0144             |       |                      | +     |              | NU147             |       | _                       |
|              |                    |        | Correction           |      |           |                   |       | Correction           |       |              |                   |       | Correction              |
|              |                    |        | Completed            |      |           |                   |       | Completed            |       |              |                   |       | Completed               |
| ID Prefix    |                    |        |                      |      | ID Prefix |                   |       |                      |       | ID Prefix    |                   |       | _                       |
| Reg. #       |                    |        |                      |      | Reg. #    |                   |       |                      |       | Reg. #       |                   |       | _                       |
| LSC          |                    |        |                      |      | LSC       |                   |       |                      |       | LSC          |                   |       |                         |
|              |                    |        | 0                    |      |           |                   |       | 0                    |       |              |                   |       | 0                       |
|              |                    |        | Correction Completed |      |           |                   |       | Correction Completed |       |              |                   |       | Correction<br>Completed |
| ID Prefix    |                    |        | Completed            |      | ID Prefix |                   |       | Completed            |       | ID Prefix    |                   |       |                         |
| Reg. #       |                    |        |                      |      | Reg. #    |                   |       |                      |       |              |                   |       |                         |
| LSC          |                    |        |                      |      | LSC       |                   |       |                      |       | LSC          |                   |       | _                       |
|              |                    |        |                      |      |           |                   |       |                      |       |              |                   |       |                         |
|              |                    |        | Correction           |      |           |                   |       | Correction           |       |              |                   |       | Correction              |
| ID Prefix    |                    |        | Completed            |      | ID Prefix |                   |       | Completed            |       | ID Prefix    |                   |       | Completed               |
| Reg.#        |                    |        |                      |      | Reg.#     |                   |       |                      |       |              |                   |       | _                       |
|              |                    |        |                      |      |           |                   |       |                      |       | LSC          |                   |       | <u>-</u> ,<br>-         |
|              |                    |        |                      |      |           |                   |       |                      |       |              |                   |       |                         |
|              |                    |        | Correction           |      |           |                   |       | Correction           |       |              |                   |       | Correction              |
| ID Prefix    |                    |        | Completed            |      | ID Prefix |                   |       | Completed            |       | ID Prefix    |                   |       | Completed               |
| Reg.#        |                    |        |                      |      | Reg.#     |                   |       |                      |       | D #          |                   |       |                         |
|              |                    |        |                      |      |           |                   |       |                      |       | LSC          |                   |       | _<br>_                  |
|              |                    |        |                      |      |           |                   |       |                      |       |              |                   |       |                         |
| Reviewed By  | Revio              | ewed B | S <b>v</b>           | Da   | te:       | Signature of      | Surve | vor:                 |       |              |                   | Date: |                         |
| State Agency |                    |        | /KJ                  |      | 5/2016    | 0.5               | _ 20  | 347                  | 64    |              |                   |       | 18/2015                 |
| Reviewed By  |                    | ewed B |                      | Da   |           | Signature of      | Surve |                      |       |              |                   | Date: | , =010                  |
| CMS RO       |                    |        | -                    |      |           | 3                 |       | -                    |       |              |                   |       |                         |
| Followup to  | Survey Completed o | n:     |                      |      |           | Check fo          | r any | Uncorrected I        | Defic | iencies. Was | a Summary of      | 1     |                         |
|              | 11/3/2015          |        |                      |      |           |                   | •     |                      |       |              | to the Facility?  | YES   | NO                      |

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: F5CI

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

|  | PART                               | I - TO BE COM  | PLETED BY T                            | THE STAT                      | E SURVEY A                      | AGENCY   | 1  | Facility ID: 00019                                   |
|--|------------------------------------|--|--|-------------------------------|---------------------------------|--|--|--|
| MEDICARE/MEDICAID PROVIDER N     (L1) 245278  2.STATE VENDOR OR MEDICAID NO.     (L2) 608716700    | 10.                                | 3. NAME AND AD (L3) GOOD SAM (L4) 413 13TH A (L5) HOWARD L | ARITAN SOCIE<br>VENUE                  |                               |                                 | 6) 55349   | 4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation                                    | 2. Recertification 4. CHOW 6. Complaint              |
| 5. EFFECTIVE DATE CHANGE OF OW (L9)  | NERSHIP                            | 7. PROVIDER/SUI  | PPLIER CATEGOR                         | Y<br>09 ESRD                  |                                 | L7)<br>22 CLIA   | 7. On-Site Visit  8. Full Survey After Co  | 9. Other<br>omplaint                                 |
| 6. DATE OF SURVEY 11/05  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other              | / <b>2015</b> (L34)<br>(L10)       | 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF                   | 06 PRTF<br>07 X-Ray<br>08 OPT/SP       | 10 NF<br>11 ICF/IID<br>12 RHC | 14 CORF<br>15 ASC<br>16 HOSPICE | Σ  | FISCAL YEAR ENDING   | G DATE: (L35)  |
| 11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds | 35 (L18)<br>35 (L17)               | A. In Complian Program Re Compliance1. A  X B. Not in Com  | equirements                            | n                             | 2. T<br>3. 2.<br>4. 7           | echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code  B* | e Following Requirements:  6. Scope of Serv 7. Medical Direc 8. Patient Room 9. Beds/Room  (L12) | etor   |
| 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 35  | 19 SNF                             | ICF  | IID                                    |                               | 15. FACILITY<br>1861 (e) (1)    | MEETS<br>or 1861 (j) (1):  | (L15)  |  |
| (L37) (L38)  16. STATE SURVEY AGENCY REMARK  | (L39)<br>SS (IF APPLICABLE S       | (L42)<br>HOW LTC CANCELI                                   | (L43)<br>LATION DATE):                 |                               |                                 |  |  |  |
| 17. SURVEYOR SIGNATURE   |                                    | Date :   |  |                               | 18. STATE SU                    | URVEY AGENCY AP  | PROVAL   | Date:  |
| Michelle Thomps  | on, HFE NE                         | II   | 12/08/2015                             | (L19)                         | Kate Jo                         | ohnsTon, Pi  | rogram Speciali  | st 12/08/2015 (L20)                                  |
|  | PART II - TO                       | BE COMPLETE  | D BY HCFA RI                           | EGIONAI                       | OFFICE OF                       | R SINGLE STAT  | E AGENCY   |  |
| 19. DETERMINATION OF ELIGIBILITY  1. Facility is Eligible to Par                                   |                                    |  | MPLIANCE WITH C<br>HTS ACT:            | CIVIL                         | 2                               |  | ial Solvency (HCFA-2572)<br>Interest Disclosure Stmt (HCF  | A-1513)  |
| 2. Facility is not Eligible  | (L21)                              |  |  |                               |                                 |  |  |  |
| 22. ORIGINAL DATE OF PARTICIPATION 04/01/1985 (L24)  | 23. LTC AGREEMI<br>BEGINNING (L41) |  | 24. LTC AGREEMI<br>ENDING DAT<br>(L25) |                               | VOLUNTARY<br>01-Merger, Cl      |  | INVOLUN'<br>05-Fail to M   | (L30) <u>TARY</u> Icet Health/Safety  Icet Agreement |
| 25. LTC EXTENSION DATE:  | 27. ALTERNATIVI A. Suspension of   |  | (L44)                                  |                               |                                 | oluntary Termination<br>on for Withdrawal                            | OTHER<br>07-Provider<br>00-Active  | Status Change  |
| (L27)  | B. Rescind Sus                     | pension Date:  | (L45)                                  |                               |                                 |  |  |  |
| 28. TERMINATION DATE:  | 29                                 | . INTERMEDIARY/C   | CARRIER NO.                            |                               | 30. REMARK                      | T.S.   |  |  |
|  | (L28)                              | 00140  |  | (L31)                         |                                 |  |  |  |
| 31. RO RECEIPT OF CMS-1539   | 32                                 | . DETERMINATION (  | OF APPROVAL DA                         | TE                            | Posted 12                       | /09/2015 Co.   |  |  |
|  | (L32)                              |  |  | (L33)                         | DETERMI                         | NATION APPRO   | VAL  |  |



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

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

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

#### DEPARTMENT CONTACT

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

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

Good Samaritan Society - Howard Lake November 20, 2015 Page 3

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

Good Samaritan Society - Howard Lake November 20, 2015 Page 4

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.

Good Samaritan Society - Howard Lake November 20, 2015 Page 5

All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program

Health Regulation Division

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 12/08/2015 FORM APPROVED OMB NO. 0938-0391

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` ′                |     | LE CONSTRUCTION  | ` '  | E SURVEY<br>IPLETED        |
|--------------------------|--|---|--------------------|-----|--|------|----------------------------|
|                          |  | 245278  | B. WING            |     |  | 11/  | 05/2015                    |
|                          | PROVIDER OR SUPPLIER  AMARITAN SOCIETY   | - HOWARD LAKE   |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349                      | -    |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | ) BE | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT  |   | F(                 | 000 |  |      |                            |
| F 157<br>SS=D            | as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electror be used as verificated. An investigation of completed, and substant F157, F313, F41  Upon receipt of an on-site revisit of your validate that substant regulations has been your verification.  483.10(b)(11) NOT (INJURY/DECLINE)  A facility must immed consult with the resist known, notify the resist or an interested fand accident involving the injury and has the printervention; a significant physical, mental, or deterioration in hear status in either life to clinical complications significantly (i.e., a existing form of treat consequences, or to treatment); or a decrease in existing form of treatment); or a decrease in the printervention of the consequences, or to treatment); or a decrease in the printervention of the consequences, or to the printervention of the consequences, or to the printervention of the consequences, or to the printervention of the pr | complaint H5278005 was estantiated during the survey 2.  acceptable electronic POC, an our facility may be conducted to untial compliance with the en attained in accordance with | F1                 | 157 |  |      | 12/15/15                   |
| LABORATOR'               | Y DIRECTOR'S OR PROVID   | DER/SUPPLIER REPRESENTATIVE'S SIGN  | NATURE             |     | TITLE  |      | (X6) DATE                  |

Electronically Signed 11/25/2015

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.

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                 | LE CONSTRUCTION  | ` '  | SURVEY<br>PLETED           |
|--------------------------|--|--|---------------------|--|--|----------------------------|
|                          |  | 245278   | B. WING             |  | 11/0   | 5/2015                     |
|                          | PROVIDER OR SUPPLIER  AMARITAN SOCIETY   | - HOWARD LAKE  | 4                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | BE   | (X5)<br>COMPLETION<br>DATE |
| F 157                    | and, if known, the ror interested family change in room or specified in §483.1 resident rights underegulations as specified in section.  The facility must rethe address and phlegal representative.  This REQUIREMED by: Based on observative, the facility flegal guardian, fammedication change vision visits for 1 of legal guardian.  Findings include:  R32's quarterly min 8/19/15, indicated to intact, and had dented that the receives a hallucinates these fractions. | so promptly notify the resident resident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in refederal or State law or cified in paragraph (b)(1) of cord and periodically update rone number of the resident's reference or interested family member.  NT is not met as evidenced tion, interview, and document ailed to notify the residents ily member (F)-A, with s, and missed dental and and residents (R32), who had a simum data set (MDS) dated the resident was cognitively mentia and schizophrenia. | F 157               | 1) Medication change: The Name was restarted on 08/07/2015. The resident R32's legal guardian, Fam 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 present via phone. All current medi were reviewed with family member, advised of risks and benefits of each medication.  Missed dental and vision visits: Fact staff communicated with Family memory (F)-A on 11/11/15 regarding her desenroll the resident, R32, in new conproviding On-Site services. Family member wanted resident enrolled in Podiatry and Hearing, but declined and Dental services, as she will corto take her out for these services. | ily  5  6  Cations  ch  cility  ember  sire to  npany  n  Vision  ntinue |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                |    | E CONSTRUCTION  |  | SURVEY<br>PLETED                        |
|--------------------------|--|--|--------------------|----|---|--|---|
|                          |  | 245278   | B. WING            |    |   | 11/0   | 05/2015                                 |
|                          | PROVIDER OR SUPPLIEI   |  |                    | 4  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>113 13TH AVENUE<br>IOWARD LAKE, MN 55349  |  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | Х  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)   | BE   | (X5)<br>COMPLETION<br>DATE              |
| F 157                    | indicated Guardia family member (F Guardian of the al court is qualified a guardian(s) with a prescribed by stat appointing the guardian(s) with a prescribed by stat appointing the guardian of the ward under M During interview 1 she was the guard decisions, and the namenda (medica Alzheimer's disea input. F-A stated medication was sineurologist/psych want her taken off also informed F-A out to the facility a services for R32, provided and she she felt as R32's I made aware of all A Chemical Restrict dated 4/9/15, indicated 4/9/1 | nship for R32 appointed to M)-A, "Having been appointed bove named [R32] ward by the and hereby authorized to act as all the powers and authority ute as shown on the order ardian, the terms of which are in by reference including the rights and powers on behalf of inn. Stat. 524.5-313 subd. (c)."  1/3/15, at 6:03 p.m. F-A stated dian for R32's medical a facility had discontinued R32's ation to treat dementia related to se) with out her consent or she did not realize the copped until R32 went to see her intric doctor and they did not a dental company would come and provide dental and vision however, neither services were was not informed. F-A stated egal guardian, she should be | F 1                | 57 | conference held on 11/19/2015, with Family member (F)-A present via per Family member stated she sent the paperwork to Centra Sota Oral Surand they should be contacting the for medical records. Resident is ne scheduled to see the eye doctor 1 yfrom last appointment (which would 07/02/2016).  2) Medication change: All resident medication changes that have occur the last 30 days will be reviewed to the resident or resident's legal guar was notified of the change.  Missed dental and vision visits: All residents will be reviewed to ensure are current on dental and vision vision ordered.  3) Medication change: Review are re-education of GSS policy and profor notifying residents or legal guard of medication changes was provided nurses by 12/15/2015.  Missed dental and vision visits: Revand re-education of GSS policy and procedure for providing dental and services as well as notifying resident family and offering alternative servicurrent provider unable to see time be provided to facility appointment scheduler and all nurses by 12/15/2015.  4) Medication change: All medication order changes will be audited week then monthly x 2 months to ensure | hone. geons acility xt year d be  ts with urred in ensure rdian e all its as  d cedure dians d to all view d vision nt and ces if ly will 2015. tion ly x 4, |   |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                |    | E CONSTRUCTION   | ` '                                   | SURVEY<br>PLETED           |
|--------------------------|--|--|--------------------|----|--|---------------------------------------|----------------------------|
|                          |  | 245278   | B. WING            |    |  | 11/0                                  | 05/2015                    |
|                          | PROVIDER OR SUPPLIER  AMARITAN SOCIETY   | - HOWARD LAKE  |                    | 4  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>113 13TH AVENUE<br>OWARD LAKE, MN 55349  | ,                                     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)  | BE                                    | (X5)<br>COMPLETION<br>DATE |
| F 157                    | Namenda. Past rephysician respondenamenda.  A Clinic Referral for indicated the resideneurologist/psychia R32 to restart name.  During interview 11 director of nursing aware that FM-A wastated she did not imedication change the guardian.  R32's Health and Vindicated the reside open angle glaucor which damage to the progressive, irreverborderline intra occupon complicated diseas nerve leads to progressive, irreverborderline intra occupon footh eyes). The to return to the eye required to check immonths.  R32's facility Progresindicated R32 was, cloudiness and black (right) eye. Writer for service to in hour Friday, 5/29/15. We still no response or and see her. Write | May we d/c (discontinue) duction has gone well." The don 6/29/15, to discontinue  Im for R32 dated 8/7/15, ent had been seen by her tric doctor and was ordered enda 10 mg twice a day.  /04/15, at 12:36 p.m. with the (DON) who stated she was not as R32's guardian. The DON inform R32's F-A of the is and should have since she is  ision form dated 9/3/14, ent had seen an eye doctor for ina (complicated disease in ine optic nerve leads to isible vision loss) with lar pressure pseudophakia (a e in which damage to the optic ressive, irreversible vision loss document indicated R32 was clinic in 6 months, and was intra ocular pressure every 6  ess Note dated 6/2/15, "Experiencing complaints of the dot obscuring vision in R axed communication request use [eye doctor] to be seen on riter followed up Monday with indication they would come r LM [left message] with [F-A]. is morning and stated she | F 1                | 57 | notification was completed. Results reported to QAPI for further recommendations.  Missed dental and vision visits: All ordered dental and vision appointmentation follow-up visits will be audited montmonths to ensure proper notification completed. Results will be reported QAPI for further recommendations. | ents or<br>thly, x 3<br>n was<br>I to |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRAND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING |   | TIPLE CONSTRUCTION ING   |                     | (X3) DATE SURVEY<br>COMPLETED  |                                |                            |
|---|---|--|---------------------|--|--------------------------------|----------------------------|
|   |   | 245278   | B. WING             |  |                                | 11/05/2015                 |
|   | PROVIDER OR SUPPLIER  AMARITAN SOCIETY  | - HOWARD LAKE  |                     | STREET ADDRESS, CITY, STATE, ZIF<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349             |                                |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>X (EACH CORRECTIVE ACTIV<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 157   | anywhere. Daughte about residents der A clinic referral from indicated R32 now (right eye) glaucom macular degeneratidate of next appoin R32 was seen for the off site eye door Although R32 was seen for the off site eye door Although R32 was seen for the off site eye door Although R32 was seen for the off site eye door although R32 was seen for the initiate a follow up at the in house eye dowith R32, until the reproblems with visional later. R32's medical reconsumer was completed on a DDS (doctor of deindicated, "Pt (patient partial dentures that at this time. No decrestorations are in goine directed R32 was to 6 months. The facing house dentist on 4/indicating R32 had have a follow up deresponse email from indicated the family between the yearly assistance would not seen again by a deafter the initial dentidental appointment. | seen since we weren't getting er also expressed concern atal care." In the eye doctor dated 6/4/15, had, "Early macular hole OD a OD>OS (OS left eye) on." The Referral indicated timent to be in one month. The follow up appointment at tor on 7/2/15. It is een by the eye doctor on ected to have a follow up onths, the facility did not appointment, nor notify FM-A factor was unable to follow up esident began to experience in, which was almost 9 months ard indicated a dental referral ard indicated a dental referral ard indicated a dental referral ent) has upper and lower to fit well. Pt has no concerns | F 1                 | 57   |                                |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED          |                            |
|---|--|--|--|---|--|----------------------------|
|   |  | 245278   | B. WING                                |   | 11/0                                   | 05/2015                    |
|   | PROVIDER OR SUPPLIER  AMARITAN SOCIETY   | - HOWARD LAKE  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349   |  |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)  | BE                                     | (X5)<br>COMPLETION<br>DATE |
| F 166<br>SS=D                                       | Administration And indicated, "The res representative will be orders and the risk discussions will be (progress note) -Co Resident/family."  Although F-A was Finformed of medical inform F-A of a discusion appointment 483.10(f)(2) RIGHT RESOLVE GRIEVAL A resident has the facility to resolve griefless and to inform the second secon | rocedure Medication Scheduling dated 9/15, sident and/or legal be notified of new medication benefit of the medications. All documented in the PN benefit of the medication with  R32's guardian and was to be all changes the facility failed to continuation of medication form F-A of missed dental and s. TO PROMPT EFFORTS TO | F 15                                   |   |  | 12/15/15                   |
|   | by: Based on interview facility failed to protoconcerns voiced by residents (R12) rev. Findings include: R12's quarterly Minindicated that she wimpaired and had co. On 11/3/15, at 1:40   | NT is not met as evidenced and document review, the mptly resolve complaints and family members for 1 of 2 iewed for grievances.  Simum Data Set dated 8/27/15, was moderately cognitively ongestive heart failure (CHF).  p.m. family (F)-G and (F)-H he "eyes and ears" for R12  |  | <ol> <li>Meeting scheduled for 12/11/20 the facility. Members attending this meeting are resident's (R12) family members, MN Regional Ombudsm and facility staff. Purpose of the me is to ensure all family grievances have been responded to, and to develop for ongoing facility-to-family communication.</li> <li>All residents and designated facontacts will receive a mailing by 12/15/15, notifying them of our police.</li> </ol> | an,<br>eeting<br>ave<br>a plan<br>mily |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |  |  |                            |
|--|--|--|-------------------------------|--|--|----------------------------|
|  |  | 245278   | B. WING                       |  | 11/(   | 05/2015                    |
| NAME OF I  | PROVIDER OR SUPPLIER   |  |                               | STREET ADDRESS, CITY, STATE, ZIP   |  |                            |
| GOOD S   | AMARITAN SOCIETY   | / - HOWARD LAKE  |                               | 413 13TH AVENUE<br>HOWARD LAKE, MN 55349   |  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG            | PROVIDER'S PLAN OF CO<br>X (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY)   | N SHOULD BE<br>E APPROPRIATE   | (X5)<br>COMPLETION<br>DATE |
| F 166  | and they both and explained that R12 hospitalization for issues. F-G stated registered nurse (FLasix (medication to heart failure) who stay from 09/30/15 that she was unawe the Lasix after she hospital on 09/16/20 During an interview director of nursing stated they were a regarding R12's Lanot followed on the and was unsure if The administrator to F-G about the Lanother facility stawas unsure.  On 11/05/15, at 5: with F-G on the exconcerns with R12 hospitalization's. For orders and informed and thought the Dogoing to contact the complaint.  Although F-G addirectiving her Lasix hospitalizations, the family members con a policy was requested. | advocate for R12. F-G has had recurrent pulmonary and respiratory she had spoken with RN)-A regarding R12's order for used to treat fluid build-up due ten R12's return from hospital is-10/02/15. The F-G stated ware that R12 had not continued was discharged from the 15.  If on 11/05/15, at 5:01 p.m. the (DON) and administrator both ware of F-G's concern asix. The DON stated she had be concern expressed by F-G, RN-A had followed with F-G. stated she also had not spoken asix complaint but maybe ff may have spoken to F-G but  10 p.m. RN-A stated she spoke ening of 10/2/15, about her It's Lasix order and IN-A stated she reviewed the ed the DON of F-G's concerns, ON and or adminstrator was e family to follow up on their  ressed a concern of R12 not and requiring recurrent e facility did not respond to the | F 1                           | regarding Grievances, Cor Concerns, along with a cop Suggestion/Concern form, to them to please complete contact us if they have any unresolved grievances, coconcerns.  3) Suggestion/Concern for located in the main lobby for family member to access every resident care confert opportunity will be taken to are any concerns. At every council meeting, an opport taken to inquire if there are A sample Suggestion/Condirections for completion is main hallway, across from Nursing's office. Re-educa provided to all staff on GSI regarding Grievances, Concerns. Any grievance, concern brought forth will be according to GSS policy are for Grievances, Complaint  4) All Grievances, Complaint  4) All Grievances, Complaint  4) All Grievances, Complaint  Concerns will be tracked of Suggestion/Concern form QAPI Coordinator/Social Sidesignee maintains this log QAPI committee monthly. completed monthly x 3 mo Grievances, Complaints or ensure GSS policy and proresolution is followed, with reported to QAPI committee monthly recommendations. | and a request enter form or and a request enter form or a current or implaints or implaints or implaints or inquire if there are any concerns. In a concerns or complaint or inquire if the concern form with the concern form with the concern form will be so policy implaints or complaint or inquire if the concerns. It is located in the concerns or complaint or interest or concerns. It is or in the intracking log. Service in the concerns to concern to |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | TIPLE CONSTRUCTION  NG  |   | E SURVEY<br>PLETED         |
|--------------------------|---|---|---------------------|---|---|----------------------------|
|                          |   | 245278  | B. WING             |   | 11/0                                    | 05/2015                    |
|                          | PROVIDER OR SUPPLIER  AMARITAN SOCIETY  | - HOWARD LAKE   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349   | ,                                       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | _D BE                                   | (X5)<br>COMPLETION<br>DATE |
| F 166 F 241 SS=D         | the Grievance polic When resident, fam member expresses staff member relate it will be received in nonjudgmental mar reprisal. In Step 5, i must be done for al grievances were no would be notified. Grievances would be days.  483.15(a) DIGNITY INDIVIDUALITY  The facility must promanner and in an elenhances each res full recognition of his | 08/15. As outlined in Step 1, y is to be utilized as follows: nily member, visitor or staff a concern or grievance to a ed to resident care or services,                                  | F 1                 |   |   | 12/15/15                   |
|                          | by: Based on observat review the facility fa dinning for 1 of 1 re assisted with eating feeding her. Findings include: R23's quarterly min 8/27/15, indicated to cognitive impairment assistance with eating  | ion, interview, and document tiled to provide dignified esidents (R23) observed being by staff who stood while imum data set (MDS) dated the resident had severe and required total staff |                     | <ol> <li>Resident R23 is being provided dignified dining by having staff sit assisting her. R23's wheelchair was re-evaluated resulting in R23 beir in smaller-scale, more-appropriate wheelchair on 11/11/2015.</li> <li>All residents who require ass with eating and drinking will be reby 12/10/15 to ensure they are be provided dignified dining.</li> <li>All nursing and dietary staff was re-educated on providing dignified.</li> </ol> | while as ag placed e stance viewed eing |                            |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                 | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|---------------------|--|-------------------------------|----------------------------|
|   |   | 245278   | B. WING             |  | 11/0                          | 05/2015                    |
|   | PROVIDER OR SUPPLIER  AMARITAN SOCIETY  | - HOWARD LAKE  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)   | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 313<br>SS=D                                       | drinking.  During observation nursing assistant (NR23 soup, a sandw Throughout the corp.m. to 6:10 p.m., NAt 5:40 p.m. NA-K tablemate and stoopoured her soup in back by R23, and of feeding her.  During observation to 9:05 a.m. NA-L wR23's room and feed NA-L tossed the spand quickly left R23.  During interview on dietary director (DD while feeding reside large," but staff shouch as a different assisting R23 with a such as a different as | on 11/04/15, at 5:31 p.m. NA)-K was observed feeding ich, and a beverage. Istant observation from 5:31 NA-K stood while feeding R23. Invalved over to R23's dependent of the resident and a cup. NA-K then walked ontinued to stand while  on 11/05/15, from 9:00 a.m. Invas observed standing in reding her yogurt. At 9:05 a.m., recon and cup in the garbage, recommendent of the resident and set of the resident and a cup. NA-K then walked ontinued to stand while  on 11/05/15, from 9:00 a.m. In 1/05/15, at 10:00 a.m. | F 241               | by 12/15/15.  4) Audits of residents who require assistance with eating and drinking completed weekly x 4, then monthl to ensure staff are providing a dign dining experience, with results report QAPI committee for further recommendations. | y will be<br>y x 2,<br>ified  | 12/15/15                   |
|   |   | dents receive proper treatment es to maintain vision and   |                     |  |                               |                            |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | E CONSTRUCTION  |  | SURVEY<br>PLETED           |
|--------------------------|--|--|---------------------|---|--|----------------------------|
|                          |  | 245278   | B. WING             |   | 11/0   | 05/2015                    |
|                          | PROVIDER OR SUPPLIER   |  | 4                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>113 13TH AVENUE<br>HOWARD LAKE, MN 55349  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | D BE   | (X5)<br>COMPLETION<br>DATE |
| F 313                    | hearing abilities, the assist the resident by arranging for tra office of a practition treatment of vision office of a professi provision of vision.  This REQUIREMED by: Based on interview facility failed to professidents (R32) revision of vision.  This REQUIREMED by: Based on interview facility failed to professidents (R32) revision.  Findings include: R32's quarterly min 8/19/15, indicated intact, and had deresident had, "Psyrelated to schizoph that she receives a hallucinates these.  R32's medical record document dated a indicated Guardiar family member (F) Guardian of the about the court is qualified a guardian(s) with all prescribed by status appointing the guardincorporated herei | in efacility must, if necessary, in making appointments, and ansportation to and from the ner specializing in the or hearing impairment or the onal specializing in the or hearing assistive devices.  ENT is not met as evidenced w, and document review, the evide vision services for 1 of 1 viewed for vision.  Inimum data set (MDS) dated the resident was cognitively mentia and schizophrenia.  Inted 8/13/15, indicated the chosocial well being problem arenia and may believe ideas are real, or verbalizes, or | F 313               | <ol> <li>Facility staff communicated w Family member (F)-A on 11/11/15 regarding her desire to enroll the r R32 in new company providing Or services. Family member wanted enrolled in Podiatry and Hearing, I declined Vision and Dental services she will continue to take her out for services. Resident is currently upon vision appointments. Resident scheduled to see the eye doctor 1 from last appointment (which wou 07/02/2016).</li> <li>All residents will be reviewed 12/15/15 to ensure all are current vision visits as ordered.</li> <li>To ensure all resident vision s needs are met, review and re-edu GSS policy and procedure for provision services and offering alternaservices if current provider unable timely will be provided to facility appointment scheduler and all nur 12/15/2015.</li> <li>All ordered vision appointment</li> </ol> | resident n-Site resident out es, as or these to-date is next year ld be  oy on  ervice cation of viding ative to see |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|---|--|-----|---|-------------------------------|----------------------------|
|   |   | 245278  | B. WING                                |     |   | 11/0                          | 05/2015                    |
|   | PROVIDER OR SUPPLIER  AMARITAN SOCIETY  | - HOWARD LAKE   |  | 4   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>113 13TH AVENUE<br>OWARD LAKE, MN 55349   |                               |                            |
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| F 313   | she was responsible and care, and the find doctor would come follow up vision apprehat service was not notified until the residual with her vision, and appointment with a R32's Health and Vindicated the residual open angle glaucor which damage to the progressive, irrever borderline intra occupation of both eyes). The to return to the eye | /3/15, at 6:03 p.m. F-A stated e for R32's medical decisions acility had informed her a eye out to the facility to provide a pointment for R32. However, at provided and F-A was not sident began to have problems F-A had to make a eye doctor   | F3                                     | 313 | follow-up visits will be audited mon months to ensure vision service ne met. Results reported to QAPI for frecommendations. | eds are                       |                            |
|   | indicated R32 was, cloudiness and black (right) eye. Writer of for service to in hour Friday, 5/29/15. We still no response or and see her. Write [F-A] called back the would be making a doctor] to have her anywhere."  A clinic referral from indicated R32 now  | "Experiencing complaints of ck dot obscuring vision in R faxed communication request use [eye doctor] to be seen on riter followed up Monday with indication they would come r LM [left message] with [F-A]. is morning and stated she in appointment [with eye seen since we weren't getting in the eye doctor dated 6/4/15, had, "Early macular hole OD a OD>OS (OS left eye) |  |     |   |                               |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |  | (X3) DATE SURVEY<br>COMPLETED |                            |
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|                          |  | 245278   | B. WING                                |   |  | 11/0                          | 05/2015                    |
|                          | PROVIDER OR SUPPLIER  AMARITAN SOCIETY   | - HOWARD LAKE  |  | STREET ADDRESS, CITY, S<br>413 13TH AVENUE<br>HOWARD LAKE, MN   |  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     | (EACH CORRECTION (EACH | PLAN OF CORRECTION<br>TIVE ACTION SHOULD<br>CED TO THE APPROPE<br>EFICIENCY) | BE                            | (X5)<br>COMPLETION<br>DATE |
| F 313                    | date of next appoint R32 was seen again appointment at the On 11/5/15, at 3:55 stated they had a bivision services and new contract with a The administrator significant when they said they problems for the fathough R32 was 9/3/14, and was direappointment in 6 mm F-A the in house eyup with R32, until the experience problem almost 9 months lath 483.25(I) DRUG REUNNECESSARY Description of the Each resident's drug unnecessary drugs drug when used in duplicate therapy); without adequate mindications for its usadverse consequer should be reduced combinations of the Based on a compressident, the facility who have not used given these drugs a diagnosed and composed an | ion." The Referral indicated the then to be in one month. In for the follow up off site eye doctor on 7/2/15. p.m. the facility administrator ad experience with In-House in October 2015, signed a new vision service company. It is that they did not show up yould, and it caused a lot of cility and the residents. It is seen by the eye doctor on ected to have a follow up onths, the facility did not notify the doctor was unable to follow the resident began to the swith vision, which was ter.  EGIMEN IS FREE FROM PRUGS  They regimen must be free from the case of the cas | F3                                     |   |  |                               | 12/15/15                   |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | IDENTIFICATION NUMBED:   |                     | X2) MULTIPLE CONSTRUCTION A. BUILDING  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|--|--|-------------------------------|--|
|   |  | 245278   | B. WING             |  | 11/0   | 05/2015                       |  |
|   | PROVIDER OR SUPPLIE  | R<br>Y - HOWARD LAKE   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349  | · · · · · · · · · · · · · · · · · · ·  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE DEFICIENCY)   | SHOULD BE  | (X5)<br>COMPLETION<br>DATE    |  |
| F 329   | behavioral interve<br>contraindicated, in<br>drugs.  | dual dose reductions, and entions, unless clinically an effort to discontinue these  | F3                  | 29   |  |                               |  |
|   | by: Based on intervie facility failed to coprovide medical jumedication used for 1 of 5 resident unnecessary medications. Findings include: R18's quarterly M8/12/15, indicated impairment and hasleep. R18's physician of an order for, "Train (antidepressant in 100 MG (milligrary bedtime related to orders identified a began to receive one year prior. R18's care plan do resident had "incrintervention to allowed and activities. The | ew and document review, the emprehensively reassess and sustification for ongoing use of a for insomnia (inability to sleep) is (R18) reviewed for dications.  Inimum Data Set (MDS) dated I R18 had no cognitive ad no trouble falling or staying and no trouble falling or staying reders dated 11/3/15, indicated ZODone HCL Tablet decication used for insomnia) ins) Give 1 tablet by mouth at a start date (date which R18 the medication) 7/29/14, over ated 4/15/14, identified the eased sleeping," with an ow R18 to sleep between meals a care plan did not identify any ions for R18's sleep despite |                     | <ol> <li>Resident R18's Trazodo reduced in dose and then di of 11/23/2015.</li> <li>All residents currently or for insomnia will be reviewed to ensure appropriate medicand monitoring for effectiver indications for ongoing use or reduction/discontinuation.</li> <li>All nursing staff will be pre-education on GSS policy procedure for monitoring eff and justification for using hy medications. In addition, all receiving hypnotic medication reviewed monthly by the Phaconsultant and Director of N ensure appropriate medical and monitoring for effectiver indications for ongoing use or reduction/discontinuation.</li> <li>Audits of residents receimedications will be complete and then monthly x 2 to ensignstification and monitoring for effectiven indications and monitoring for ensigns in the process of the process o</li></ol> | n a medication d by 12/15/15 cal justification ness and or potential provided with and ectiveness pnotic residents ons will be armacy jursing to justification ness and or potential residents on the second protection in th |                               |  |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | IPLE CONSTRUCTION  NG  |              | (X3) DATE SURVEY<br>COMPLETED |  |
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|                          |   | 245278   | B. WING _           |  | 11/0         | 05/2015                       |  |
|                          | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP (<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349             | •            | 30/2010                       |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIOI<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE  | (X5)<br>COMPLETION<br>DATE    |  |
| F 329                    | being identified as R18's Sleep Asses identified, "Res. (re experiencing NO s medical record lac assessments compevidence of any as determine if R18 s current dose.  During interview or practical nurse (LF Trazodone, "to help R18's Associated (notes dated 8/10/1 sleep disturbance Clinic of Psycholog 10/22/15, identified sleep disturbance, R18's Good Sama Medication Monitor identified the follow On 2/19/15, the phrecommendation work Trazodone dose control of the facility nursing "Advise no reduction have been unstable identify what, if any experiencing, or an attempt at reduction R18's physician remursing assessments." | razodone for insomnia, and having, "Increased sleeping."  sment dated 9/16/14, esident) is currently leep disturbances." R18's ked any further sleep pleted since 9/16/14, or sessment completed to till required Trazodone at the 11/4/15, at 1:07 p.m. licensed PN)-A stated R18 was on p him sleep."  Clinic of Psychology progress 5, identified, "No issues with or mood." Another Associated by progress note dated at R18, "Denies issues with appetite, or mood."  ritan Howard Lake Behavior - ring forms were reviewed and | F 32                | use or potential reduction/owith results reported to QA for further recommendation         | PI committee |                               |  |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | TIPLE CONSTRUCTION  NG   |           | ATE SURVEY<br>DMPLETED     |
|--------------------------|---|---|---------------------|--|-----------|----------------------------|
|                          |   | 245278  | B. WING             |  | 1         | 1/05/2015                  |
|                          | PROVIDER OR SUPPLIER  AMARITAN SOCIETY  | - HOWARD LAKE   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349                  |           | .,                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 329                    | On 6/18/15, the pharecommendation work Trazodone dose conursing staff indicated have led to [increased anxiety. Recommendation physician proving with MED" (minimus the physician did not dose reduction was Trazodone in over a Con 9/14/15, the pharecommendation work consider if Trazodo The medical record this recommendation work in the physician did not | armacist provided a hich included, "Consider if uld be reduced." The facility ted, "Recent past reductions ted] mood disturbance and and [no] change at this time." tided a response of, "Agree m effective dose), however, of provide justification of why a to not attempted for the a year.  armacist provided a hich included "Again - ne dose could be reduced." I lacked any documentation on was followed up on by | F3                  | 29   |           |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` '                 | LE CONSTRUCTION   |        | E SURVEY<br>PLETED         |
|--------------------------|---|---|---------------------|---|--------|----------------------------|
|                          |   | 245278  | B. WING             |   | 11/(   | 05/2015                    |
|                          | PROVIDER OR SUPPLIER  AMARITAN SOCIETY  | - HOWARD LAKE   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>413 13TH AVENUE<br>HOWARD LAKE, MN 55349   |        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)                                  | BE     | (X5)<br>COMPLETION<br>DATE |
| F 329 F 412 SS=D         | Sedative/Hypnotics "Residents who use gradual dose reduce interventions, unles an effort to disconti  A facility Psychopha Sedative/Hypnotics indicated, "For as lo sedative/hypnotic th beyond the manufa duration of use, the taper the medicatio contraindicated." 483.55(b) ROUTINI SERVICES IN NFS  The nursing facility an outside resource §483.75(h) of this p covered under the Sedental services to n resident; must, if ne making appointment transportation to an | armacological Medications and policy dated 8/14, indicated, e antipsychotic drugs receive tions and behavioral s clinically contraindicated, in nue these drugs."  armacological Medications and procedure dated 3/15, ong as a resident remains on a nat is used routinely and cturer's recommendations for center should attempt to n quarterly unless clinically  E/EMERGENCY DENTAL  must provide or obtain from e, in accordance with eart, routine (to the extent State plan); and emergency neet the needs of each ecessary, assist the resident in nots; and by arranging for d from the dentist's office; and residents with lost or | F 329               |   |        | 12/15/15                   |
|                          | by:<br>Based on interview<br>facility failed to ensi  | NT is not met as evidenced w and document review the ure dental service were residents (R32) reviewed for   |                     | Facility staff communicated with Family member (F)-A on 11/11/15 regarding her desire to enroll the research in new company providing On- | sident |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | ` '  | (X3) DATE SURVEY<br>COMPLETED  |                            |
|---|--|--|--|--|--|--|----------------------------|
|   |  | 245278   | B. WING                                |  | <del> </del>   | 11/(   | 05/2015                    |
| NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - HOWARD LAKE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 |  |  | 413 13TH A                             | DRESS, CITY, STATE, ZIP CODE<br>AVENUE<br>LAKE, MN 55349   | ,  |  |                            |
| PREFIX  | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG                    | (E.  | PROVIDER'S PLAN OF CORRECTIC<br>CACH CORRECTIVE ACTION SHOULI<br>DSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | D BE   | (X5)<br>COMPLETION<br>DATE |
| F 412   | Findings include: R32's quarterly min 8/19/15, indicated intact, and had der  During interview 11 stated she was the decisions, and the dentist would come dental services, ho provided and she was the could ensure in the 6 months as haresidents last dental services. R32's medical recompleted on 7/14. DDS (doctor of derindicated, "Pt (pating partial dentures that at this time. No derestorations are in directed R32 was to 6 months. The facility sent and on 4/04/15, (nine in had a previous recompleted in house of would have to pay visits since (MA) in cover the visit. R3 dentist until 9/24/15 dental appointment on 9/2 molar filling and poduring interview or facility administration. | nimum data set (MDS) dated the resident was cognitively mentia and schizophrenia.  /3/15, at 6:03 p.m. family (F)-A guardian for R32's medical facility had informed F-A a e out to the facility and provide wever, the service was not was not made aware timely so R32 had dental follow up within ad been directed at the al visit.  ord indicated a referral was /14, and she was seen by a ntal surgery) and the referral ent) has upper and lower at fit well. Pt has no concerns ocay noted. Existing good condition." The Referral o return for a follow up visit in | F 4                                    | service enrolle decline she wil service 11/19/2 present she se Oral Structure (Contact 2) All 12/15/2 dental 3) To needs GSS p dental service timely appoin 12/15/2 4) All followmonths are me | es. Family member wanted in Podiatry and Hearing, bed Vision and Dental service II continue to take her out for es. Care conference held on 2015, with Family member (at via phone. Family member the paperwork to Centra surgeons and they should be eating the facility for medical relating the facility for medical relations as ordered.  I residents will be reviewed to 15 to ensure all are current exists as ordered.  I residents will be reviewed to 15 to ensure all resident dental seare met, review and re-education and procedure for proving services and offering alternates if current provider unable will be provided to facility attent scheduler and all nur 2015.  I ordered dental appointment to ensure dental service near the recommendations. | out es, as or these of F)-A r stated Sota elecords.  by on ervice cation of viding ative to see ses by  ts or onthly, x 3 eeds |                            |

|  | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '   | TIPLE CONSTRUCTION  | (X3) DA   | TE SURVEY<br>MPLETED       |  |
|--|--|--|---|---|-----------|----------------------------|--|
|  |  | 245278   | B. WING   |   | 11        | /05/2015                   |  |
| NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - HOWARD LAKE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349 |   |           |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |  |
| F 412  | showing up for approved, and in Octobrew contract with a provide resident de Although the dental | ointments when they said they per 2015, they had signed a new dental company to ntal care at the facility.  record's indicated R32 was to sit in 6 months, she was not | F 4   | 12  |           |                            |  |

F5278025

PRINTED: 12/01/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245278 B. WING 11/03/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **413 13TH AVENUE GOOD SAMARITAN SOCIETY - HOWARD LAKE** HOWARD LAKE, MN 55349 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS 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

Electronically Signed

(X6) DATE

TITLE

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.

Facility ID: 00019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

| STATEMENT  | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                   |     | E CONSTRUCTION<br>01 - MAIN BUILDING 01   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|-------------------|-----|---|-------------------------------|----------------------------|
|  |   | 245278  | B. WING           |     |   | 11/0                          | 3/2015                     |
| NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - HOWARD LAKE |   |   |                   | 4   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>113 13TH AVENUE<br>IOWARD LAKE, MN 55349                                |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETION<br>DATE |
| K 000  | Angela.Kappenma   | tate.mn.us<br>itney@state.mn.us> and  | К                 | 000 |   |                               |                            |
|  |   | RRECTION FOR EACH<br>IT INCLUDE ALL OF THE<br>DRMATION:   |                   |     |   |                               | in.                        |
|  | 1. A description of to correct the defic  | what has been, or will be, done ency.   |                   |     |   |                               |                            |
|  | 3. The name and/oresponsible for cor  | oposed, completion date.  r title of the person rection and monitoring to ence of the deficiency  |                   |     |   |                               |                            |
| -  | one-story building v<br>building was construct<br>additions construct                                 | ociety Howard Lake is a with no basement. The original ructed in 1971, with building ed in 1983 and 1994. All ire sprinkler protected and be of Type II(111)                  |                   |     |   |                               | r                          |
| K 062  | detection in the concorridors which is redepartment notifical capacity of 35 beds time of the survey. | re alarm system with smoke<br>ridors and spaces open to the<br>monitored for automatic fire<br>ation. The facility has a<br>s and had a census of 26 at<br>FETY CODE STANDARD | K                 | 062 |   |                               | 12/15/15                   |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01 |  |  | (X3) DATE SURVEY COMPLETED |   |   |                    |                            |  |
|---|--|--|----------------------------|---|---|--------------------|----------------------------|--|
|   |  | 245278   | B. WING                    |   |   | 11/0               | 3/2015                     |  |
| NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - HOWARD LAKE  |  |  |                            | STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349 |   |                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFI<br>TAG         | REFIX (EACH CORRECTIVE ACTION SHOUL   |   | BE                 | (X5)<br>COMPLETION<br>DATE |  |
| K 062<br>SS=F   | continuously mainta<br>condition and are in  | ge 2<br>sprinkler systems are<br>ained in reliable operating<br>aspected and tested<br>.6, 4.6.12, NFPA 13, NFPA 25,   | K                          | 062   |   |                    |                            |  |
|   | Based on observar<br>maintain the fire sp<br>with the provisions<br>19 and NFPA 13 (1  |  |                            |   | 1. The water pressure gauge on a sprinkler system riser will be replaced dated as required. Proper docume will be acquired and maintained as required per the Life Safety Code.  2. This will be completed by 12/19 | ced and<br>ntation |                            |  |
| 5   | on 11/03/2015, it w. pressure gauge on was not marked wit interview with facilit could be provided v. system gauge had within the previous practice was not in | ween 9:30 am and 12:00 PM as observed the water the fire sprinkler system riser th a date. In a subsequent sy staff, no documentation verifying the fire sprinkler been recalibrated or replaced five (5) years. This deficient accordance with the PA 25 (1998 edition) Chapter |                            |   | 3. The Director of Environmental Services is responsible for this cor and monitoring to prevent a recurrent this deficiency.  |                    |                            |  |
| K 144<br>SS=F   | Generators are ins   | ces Director (CZ) FETY CODE STANDARD pected weekly and exercised ninutes per month in  | <b>K</b> :                 | 144   |   |                    | 11/4/15                    |  |

PRINTED: 12/01/2015 FORM APPROVED OMB NO. 0938-0391

| CENTER  | S FOR MEDICARE  | & MEDICAID SERVICES  |  |  | OND 14  | 0. 0936-0391                  |  |
|---|---|--|--|--|---|-------------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | ULTIPLE CONSTRUCTION<br>LDING <b>01 - MAIN BUILDING 01</b> |   | (X3) DATE SURVEY<br>COMPLETED |  |
|   |   | 245278   | B. WING  |  |   | 1/03/2015                     |  |
|   | ROVIDER OR SUPPLIER   | - HOWARD LAKE  |  | 4  | REET ADDRESS, CITY, STATE, ZIP CODE<br>13 13TH AVENUE<br>OWARD LAKE, MN 55349   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)         | ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) |  |   | (X5)<br>COMPLETION<br>DATE    |  |
| K 144   | Continued From pa   | age 3  | K 1  | 44   |   |                               |  |
| K 147<br>SS=D                                       | NFPA 101 (2000) REGULATION - Goveekly and exercis 30% of the EPS naper month and sha 99 (1999 edition) a This STANDARD is Based upon a staff available records, if weekly inspections for the emergency emergency, this de affect all residents, This deficient prace Environmental Serv NFPA 101 LIFE SA Electrical wiring an with NFPA 70, Nati | tice was verified by   | K  | 147  | <ol> <li>Weekly, monthly and annual inspection, testing and documentation of the Emergency Generator will occur as required per the Life Safety Code.</li> <li>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.</li> <li>The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence this deficiency.</li> </ol> | nm<br>n                       |  |
|   | Based on observa  | ation and interview, electrical of the in accordance with NFPA 70 otrical Code 1999 edition. |  |  | <ol> <li>The appliance that was plugged into<br/>power strip is now plugged directly into<br/>wall outlet as required per the Life Safe</li> </ol>  | a                             |  |

Event ID: F5CI21

PRINTED: 12/01/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245278 B. WING 11/03/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **413 13TH AVENUE GOOD SAMARITAN SOCIETY - HOWARD LAKE HOWARD LAKE, MN 55349** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 147 K 147 | Continued From page 4 section 9.1.2. This deficiency could negatively Code. effect the 5 of 26 residents. This was completed on 11/04/15. Findings include: The Director of Environmental On facility tour between 9:30 am and 12:00 PM Services is responsible for this correction on 11/03/2015, it was observed: and monitoring to prevent a recurrence of this deficiency. 1. The washing machine was plugged into a power strip in the laundry room. This deficient practice was verified by Environmental Services Director (CZ)

Event ID: F5CI21



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Good Samaritan Society - Howard Lake November 20, 2015 Page 2

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, Program Specialist Licensing and Certification Program

Kumalu Fishe Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Minnesota Department of Health

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | o. '  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                                   |  |
|--------------------------|--|---|---|---|-----------------------------------|--|
|                          |  | 00019   | B. WING _   |   | 11/05/2015                        |  |
| NAME OF                  | PROVIDER OR SUPPLIER   |   | REET ADDRESS, CITY                                      | , STATE, ZIP CODE   |                                   |  |
| GOOD S                   | AMARITAN SOCIETY   | - HOWARD I AKE  | 3 13TH AVENUE<br>WARD LAKE, MN                          | N 55349   |                                   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULI<br>SC IDENTIFYING INFORMATION  |   | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | LD BE COMPLETE                    |  |
| 2 000                    | Initial Comments   |   | 2 000   |   |                                   |  |
|                          | ****ATTE   | NTION*****  |   |   |                                   |  |
|                          | NH LICENSING   | CORRECTION ORDER  |   |   |                                   |  |
|                          | 144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber arule contain comply with any of lack of compliance. re-inspection with a result in the assess | hether a violation has be   | ued it is d ation nce e of en ow. to red on will e item |   |                                   |  |
|                          | that may result from<br>orders provided tha<br>the Department with   | hearing on any assessment non-compliance with the standard witten request is mathin 15 days of receipt of ent for non-compliance.                             | ese<br>de to  |   |                                   |  |
| Minnesota D              | receipt of State lice<br>the Minnesota Depa<br>Informational Bullet<br>http://www.health.si<br>obul.htm The Stat<br>delineated on the a  | participate in the electronsure orders consistent artment of Health in 14-01, available at tate.mn.us/divs/fpc/profine licensing orders are ttached Minnesota | with<br>nfo/inf   | On November 2-5th, 2015 survey this Department's staff, visited the provider and the following correct orders are issued. In addition, an investigation of complaint H53600 completed. The complaint was substantiated. Correction orders | e above<br>ion<br>015 was<br>were |  |
| _ABORATOR                | Y DIRECTOR'S OR PROVID   | ER/SUPPLIER REPRESENTATI  | /E'S SIGNATURE  | TITLE   | (X6) DATE                         |  |

Electronically Signed 11/25/15

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |                     |   | (X3) DATE SURVEY<br>COMPLETED                       |                          |
|--|--|--|---------------------|---|---|--------------------------|
|  |  |  | A. BOILDING.        |   |   |                          |
|  |  | 00019  | B. WING             | <del></del>   | 11/0  | 5/2015                   |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET ADI   | ORESS, CITY, S      | STATE, ZIP CODE   |   |                          |
| GOOD S   | AMARITAN SOCIETY   | - HOWARD LAKE 413 13TH<br>HOWARD   | AVENUE<br>LAKE, MN  | 55349   |   |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)   | .D BE   | (X5)<br>COMPLETE<br>DATE |
| 2 000  | Department of Hea you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff, the following correctompliant investigate compliant investigate complaint. Please indicate in your complaint. Please indicate in your and identify the date. Minnesota Department the State Licensing federal software. To assigned to Minnesota Nursing Homes.  The assigned tag in column entitled "ID statute/rule out of consuming the statement evidence by." Follower the Suggested Time period for Consumer period for C | Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  2015 surveyors of this visited the above provider and ction orders are issued. A tion was also completed for 25 and was substantiated. Here issued as a result of the rour electronic plan of have reviewed these orders, e when they will be completed. Health is documenting ag numbers have been sota state statutes/rules for the state statutes/rules for comply" portion of the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and | 2 000               | issued at State Licensing Statute #4658.0085 A-E 0265 and Statute 4658.1320 Subp. B 1545.  When corrections are completed, sign and date, make a copy of the orders and return the original to the Minnesota Department of Health, of Compliance Monitoring, Licensi Certification Program, 3333 West St, Suite 212, St. Cloud, MN 5630 | please<br>se<br>e<br>Division<br>ng and<br>Division |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` ′   | E CONSTRUCTION       | (X3) DATE<br>COMP  | SURVEY<br>PLETED |                          |
|--|--|---|----------------------|--|------------------|--------------------------|
|  |  |   | A. BOILDING.         |  |                  |                          |
|  |  | 00019   | B. WING              |  | 11/0             | 5/2015                   |
| NAME OF  | PROVIDER OR SUPPLIER   |   |                      | STATE, ZIP CODE  |                  |                          |
| GOOD S   | AMARITAN SOCIETY   | - HOWARD LAKE   | I AVENUE<br>LAKE, MN | 55349  |                  |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE             | (X5)<br>COMPLETE<br>DATE |
| 2 000  | FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC   |   | 2 000                |  |                  |                          |
| 2 265  | A nursing home mupolicies to guide staphysicians, physicians, physicians, physicians, practitioners, and if legal representative member of a reside accident, or death. nursing services, at attending physician development of the have criteria which appropriate notifica.  A. an accident results in injury and physician interventi.  B. a significant physician, of example, a deterior psychosocial status conditions or clinical cannot be a need to all example, a need to all example, a need to | ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:  involving the resident which I has the potential for requiring on;  change in the resident's or psychosocial status, for ration in health, mental, or in either life-threatening all complications;  ter treatment significantly, for addiscontinue an existing form adverse consequences, or to | 2 265                |  |                  | 12/15/15                 |

Minnesota Department of Health

STATE FORM 6899 F5CI11 If continuation sheet 3 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  |                      |   | TE SURVEY<br>MPLETED |                          |
|---|--|--|----------------------|---|----------------------|--------------------------|
|   |  |  | 7 501251110.         |   |                      |                          |
|   |  | 00019  | B. WING              |   | 11/0                 | 5/2015                   |
| NAME OF   | PROVIDER OR SUPPLIER   |  | , ,                  | STATE, ZIP CODE   |                      |                          |
| GOODS   | AMARITAN SOCIETY   | - HOWARD LAKE  | I AVENUE<br>LAKE, MN | 55349   |                      |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE                 | (X5)<br>COMPLETE<br>DATE |
| 2 265   | Continued From pa  | ige 3  | 2 265                |   |                      |                          |
|   | resident from the n  | to transfer or discharge the ursing home; or and unexpected resident deaths.   |                      |   |                      |                          |
|   | by: Based on observat review, the facility f legal guardian, fam medication change   | ent is not met as evidenced ion, interview, and document ailed to notify the residents ily member (F)-A, with s, and missed dental and 1 residents (R32), who had a  |                      | Corrected   |                      |                          |
|   | Findings include:  |  |                      |   |                      |                          |
|   | 8/19/15, indicated t   | nimum data set (MDS) dated<br>he resident was cognitively<br>nentia and schizophrenia.   |                      |   |                      |                          |
|   | resident had, "Psyc<br>related to schizoph   | ted 8/13/15, indicated the<br>chosocial well being problem<br>renia and may believe ideas<br>re real, or verbalizes, or<br>ideas."   |                      |   |                      |                          |
|   | document dated an indicated Guardian family member (FM Guardian of the abcourt is qualified an guardian(s) with all prescribed by statu appointing the guar incorporated herein powers: All of the modern and the status of the st | ord contained a notarized and signed 5/01/08, which ship for R32 appointed to M)-A, "Having been appointed ove named [R32] ward by the and hereby authorized to act as the powers and authority te as shown on the order redian, the terms of which are an by reference including the rights and powers on behalf of an. Stat. 524.5-313 subd. (c)." |                      |   |                      |                          |

Minnesota Department of Health

STATE FORM F5CI11 If continuation sheet 4 of 20

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` '  | E CONSTRUCTION      | (X3) DATE<br>COMP  | SURVEY<br>LETED |                          |
|---|---|--|---------------------|--|-----------------|--------------------------|
|   |   |  |                     |  |                 |                          |
|   |   | 00019  | B. WING             |  | 11/0            | 5/2015                   |
| NAME OF   | PROVIDER OR SUPPLIER  |  |                     | STATE, ZIP CODE  |                 |                          |
| GOOD S  | AMARITAN SOCIETY  | - HOWARD LAKE  | HAVENUE<br>LAKE, MN | 55349  |                 |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE            | (X5)<br>COMPLETE<br>DATE |
| 2 265   | Continued From pa   | age 4  | 2 265               |  |                 |                          |
|   | she was the guardi decisions, and the namenda (medicat Alzheimer's diseas input. F-A stated s medication was stoneurologist/psychia want her taken off talso informed F-A out to the facility ar services for R32, h provided and she washe felt as R32's le made aware of all of   | /3/15, at 6:03 p.m. F-A stated an for R32's medical facility had discontinued R32's ion to treat dementia related to e) with out her consent or he did not realize the apped until R32 went to see her atric doctor and they did not the namenda. The facility had a dental company would come and provide dental and vision owever, neither services were was not informed. F-A stated gal guardian, she should be changes.   |                     |  |                 |                          |
|   | dated 4/9/15, indica namenda 10 mg (no The form was sent the facility requesting side effects of medioutweighs benefit. Symptoms of democognition." The phocognition." The phocognition of the purple | ated R32 was receiving nilligrams) orally, twice a day. to R32's primary physician by ng, "May we try reduction as ication side effects potentially Will monitor for increased entia and decrease in nysician responded on 4/15/15, nda to 5 mg in the a.m., and 10 additional request was sent to ician by the facility on 6/22/15, May we d/c (discontinue) duction has gone well." The ed on 6/29/15, to discontinue or R32 dated 8/7/15, ent had been seen by her atric doctor and was ordered enda 10 mg twice a day. |                     |  |                 |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | , ,  | E CONSTRUCTION       | (X3) DATE<br>COMP  | SURVEY<br>LETED |                          |
|---|--|--|----------------------|--|-----------------|--------------------------|
|   |  |  | 7. BOILDING.         |  |                 |                          |
|   |  | 00019  | B. WING              |  | 11/0            | 5/2015                   |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S       | STATE, ZIP CODE  |                 |                          |
| GOOD S  | AMARITAN SOCIETY   | -HOWARDIAKE  | I AVENUE<br>LAKE, MN | 55349  |                 |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE            | (X5)<br>COMPLETE<br>DATE |
| 2 265   | Continued From pa  | age 5  | 2 265                |  |                 |                          |
|   | aware that FM-A wastated she did not i   | (DON) who stated she was not<br>as R32's guardian. The DON<br>inform R32's F-A of the<br>is and should have since she is   |                      |  |                 |                          |
|   | indicated the reside open angle glaucor which damage to the progressive, irrever borderline intra occur complicated disease nerve leads to progressive leads to progressive to return to the eye required to check in months.  R32's facility Progressindicated R32 was, cloudiness and black (right) eye. Writer for service to in hoteleast open angle of the complex of the | /ision form dated 9/3/14, ent had seen an eye doctor for ma (complicated disease in ne optic nerve leads to rsible vision loss) with ular pressure pseudophakia (a se in which damage to the optic gressive, irreversible vision loss document indicated R32 was clinic in 6 months, and was ntra ocular pressure every 6  ess Note dated 6/2/15, "Experiencing complaints of ck dot obscuring vision in R faxed communication request use [eye doctor] to be seen on litter followed up Monday with |                      |  |                 |                          |
|   | still no response or<br>and see her. Write<br>[F-A] called back the<br>would be making a<br>doctor] to have her<br>anywhere. Daught<br>about residents der<br>A clinic referral from<br>indicated R32 now<br>(right eye) glaucom<br>macular degenerat<br>date of next appoin<br>R32 was seen for to<br>the off site eye doc<br>Although R32 was  | n the eye doctor dated 6/4/15, had, "Early macular hole OD na OD>OS (OS left eye) ion." The Referral indicated atment to be in one month. he follow up appointment at  |                      |  |                 |                          |

Minnesota Department of Health

STATE FORM F5CI11 If continuation sheet 6 of 20

Minnesota Department of Health

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETI  | (X3) DATE SURVEY<br>COMPLETED |  |
|--|-------------------------------|--|
| 00019 B. WING 11/05/20   | 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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION   | (X5)<br>COMPLETE<br>DATE      |  |
| 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 |                               |  |

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namenda and to inform F-A of missed dental and

STATE FORM 6899 F5CI11 If continuation sheet 7 of 20

Minnesota Department of Health

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) |  |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|--|--|------|-------------------------------|--|
|                          |   | 00019   | B. WING                                      |  | 11/0 | 5/2015                        |  |
| NAME OF I                | PROVIDER OR SUPPLIER  |   | , ,  | STATE, ZIP CODE  |      |                               |  |
| GOOD S                   | AMARITAN SOCIETY  | - HOWARD LAKE   | AVENUE<br>LAKE, MN                           | 55349  |      |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE      |  |
| 2 265                    | Continued From pa   | ge 7  | 2 265  |  |      |                               |  |
|                          | vision appointments   | S.  |  |  |      |                               |  |
|                          | The director of nurs inservice staff rega   | THOD OF CORRECTION: sing, or designee, could rding notifying the residents with treatment changes and e.  |  |  |      |                               |  |
|                          | TIME PERIOD FOR<br>(21) days.   | R CORRECTION: Twenty-one  |  |  |      |                               |  |
| 21325                    | MN Rule 4658.0729<br>Emergency Oral He  | 5 Subp. 1 Providing Routine & ealth Ser   | 21325  |  |      | 12/15/15                      |  |
|                          | home must provide<br>resource, routine de<br>needs of each resid<br>include dental exan<br>fillings and crowns,<br>oral surgery, bridge<br>orthodontic procedu<br>that are provided for | e dental services. A nursing e, or obtain from an outside ental services to meet the dent. Routine dental services minations and cleanings, root canals, periodontal care, as and removable dentures, ares, and adjunctive services or similar dental patients in the , as limited by third party cies. |  |  |      |                               |  |
|                          | by: Based on interview facility failed to ens provided for 1 of 3 dental services. Findings include: R32's quarterly min 8/19/15, indicated t intact, and had dem                       | ent is not met as evidenced and document review the ure dental service were residents (R32) reviewed for imum data set (MDS) dated he resident was cognitively nentia and schizophrenia.  /3/15, at 6:03 p.m. family (F)-A guardian for R32's medical   |  | corrected  |      |                               |  |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | ` ′  |  |  | SURVEY<br>PLETED             |                          |
|--|--|--|--|--|------------------------------|--------------------------|
|  |  | 00019  | B. WING                                    |  | 11/(                         | 05/2015                  |
|  | PROVIDER OR SUPPLIER  AMARITAN SOCIETY   | - HOWARD LAKE 413 13   | ADDRESS, CITY,<br>TH AVENUE<br>RD LAKE, MN | STATE, ZIP CODE <b>55349</b>   |                              |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 21325  | decisions, and the fidentist would come dental services, how provided and she with she could ensure Rithe 6 months as harresidents last dental R32's medical reconcompleted on 7/14/DDS (doctor of denindicated, "Pt (paties partial dentures that at this time. No decrestorations are in given directed R32 was to 6 months.  The facility sent an on 4/04/15, (nine mindicated) appointment on 9/2 wisits since (MA) more cover the visit. R32 dentist until 9/24/15 dental appointment appointment on 9/2 molar filling and positive directed would, and in Octobrow contract with a provide resident de Although the dental | acility had informed F-A a out to the facility and provide wever, the service was not as not made aware timely so 32 had dental follow up withing the deep directed at the all visit.  In dindicated a referral was 14, and she was seen by a stal surgery) and the referral ent) has upper and lower at fit well. Pt has no concerns cay noted. Existing good condition." The Referral enternation of the inhouse dentise on the later) indicating R32 mmendation to have a follow ent. The response email ental clinic indicated the fame and so a significant of the inhouse dentise on the series as a sistence would not a was not seen again by a significant of the facility had a back of the facility had a bac | a a a a a a a a a a a a a a a a a a a      |  |                              |                          |

Minnesota Department of Health

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  |                     |   | (X3) DATE<br>COMP | SURVEY                   |
|--------------------------|--|--|---------------------|---|-------------------|--------------------------|
|                          |  | 00019  | B. WING 11/         |   | 11/0              | 5/2015                   |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                     | STATE, ZIP CODE   | 1 11/0            | 0/2010                   |
| GOOD S                   | AMARITAN SOCIETY   | - HOWARD LAKE  | AVENUE<br>LAKE, MN  | 5524Q   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 21325                    | Continued From pa  | ge 9   | 21325               |   |                   |                          |
|                          | The director of nurs<br>develop and implen-<br>related to providing<br>quality assessment  | THOD FOR CORRECTION:<br>sing (DON) or designee could<br>nent policies and procedures<br>timely dental services. The<br>and assurance committee<br>om audits to ensure  |                     |   |                   |                          |
|                          | TIME PERIOD FOR days.  | R CORRECTION: Twenty (21)  |                     |   |                   |                          |
| 21535                    | MN Rule4658.1315<br>Drug Usage; Gener  | Subp.1 ABCD Unnecessary ral  | 21535               |   |                   | 12/15/15                 |
|                          | must be free from a unnecessary drug in A. in excessive therapy; B. for excessive therapy; B. for excessive therapy; C. without adece D. in the prese which indicate the odiscontinued. In addition to the depart 4658.1310, the with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fade Department of Health Care Finance This standard is included in the control of the con | quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply le Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lth and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not |                     |   |                   |                          |

Minnesota Department of Health

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:               |  | ` '                 | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|--|---------------------|--|-------------------------------|--------------------------|
|                          |   | 00019  | B. WING 11/         |  | 11/0                          | 5/2015                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  | -                             |                          |
| GOOD S                   | AMARITAN SOCIETY  | - HOWARD LAKE  | LAKE, MN            | 55349  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| 21535                    | Continued From pa   | ge 10  | 21535               |  |                               |                          |
|                          | by: Based on interview facility failed to com provide medical jus   |  |                     | corrected  |                               |                          |
|                          | Findings include:   |  |                     |  |                               |                          |
|                          | 8/12/15, indicated F  | imum Data Set (MDS) dated<br>R18 had no cognitive<br>d no trouble falling or staying   |                     |  |                               |                          |
|                          | an order for, "TraZO<br>(antidepressant me<br>100 MG (milligrams<br>bedtime related to I<br>orders identified a s | lers dated 11/3/15, indicated DDone HCL Tablet dication used for insomnia) s) Give 1 tablet by mouth at NSOMNIA." The physician start date (date which R18 e medication) 7/29/14, over             |                     |  |                               |                          |
|                          | resident had "increatintervention to allow and activities. The organis or intervention being prescribed Tr        | red 4/15/14, identified the ased sleeping," with an w R18 to sleep between meals care plan did not identify any ns for R18's sleep despite azodone for insomnia, and naving, "Increased sleeping." |                     |  |                               |                          |
|                          | identified, "Res. (resexperiencing NO slemedical record lack assessments comp                                     | sment dated 9/16/14, sident) is currently eep disturbances." R18's ded any further sleep eleted since 9/16/14, or sessment completed to  |                     |  |                               |                          |

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   |                     |  |       | SURVEY<br>LETED          |
|--------------------------|--|---|---------------------|--|-------|--------------------------|
|                          |  | 20040   | B. WING             |  |       | - 1004F                  |
| NAME 05                  |  | 00019   |                     |  | 11/0  | 5/2015                   |
|                          | PROVIDER OR SUPPLIER   | 413 13TH  | , ,                 | STATE, ZIP CODE  |       |                          |
| GOODS                    | AMARITAN SOCIETY   | - H()WARI) I AKF  | LAKE, MN            | 55349  |       |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| 21535                    | Continued From pa  | ige 11  | 21535               |  |       |                          |
|                          | determine if R18 st current dose.  | ill required Trazodone at the   |                     |  |       |                          |
|                          |  | 11/4/15, at 1:07 p.m. licensed N)-A stated R18 was on him sleep."   |                     |  |       |                          |
|                          | notes dated 8/10/19<br>sleep disturbance of<br>Clinic of Psycholog   | Clinic of Psychology progress<br>5, identified, "No issues with<br>or mood." Another Associated<br>y progress note dated<br>R18, "Denies issues with<br>appetite, or mood."   |                     |  |       |                          |
|                          |  | itan Howard Lake Behavior -<br>ing forms were reviewed and<br>ing:  |                     |  |       |                          |
|                          | recommendation w<br>Trazodone dose co<br>The facility nursing<br>"Advise no reduction<br>have been unstabled<br>identify what, if any<br>experiencing, or an<br>attempt at reduction<br>R18's physician resonursing assessment<br>provide any rational | armacist provided a chich included, "Consider if the culd possibly [be] reduced?" staff identified on the form, ons; Mood anxiety [sic] levels e." The nursing staff did not expense identified why an an could not be attempted. Sponse identified, "Agree [with] of the include the physician did not le addressing why a reduction expense was not be attempted. |                     |  |       |                          |
|                          | recommendation w<br>Trazodone dose co<br>nursing staff indicat<br>have led to [increas<br>anxiety. Recomme<br>The physician prov   | armacist provided a which included, "Consider if wald be reduced." The facility ted, "Recent past reductions sed] mood disturbance and end [no] change at this time." ided a response of, "Agree m effective dose), however,  |                     |  |       |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---|---------------------|---|-------------------------------|--------------------------|
|   |   | 00019   | B. WING             |   | - 11/05/2                     |                          |
| NAME OF   | PROVIDER OR SUPPLIER  |   |                     | STATE, ZIP CODE   |                               |                          |
| GOODS   | AMARITAN SOCIETY  | - HOWARD LAKE   | LAKE, MN            | 55349   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| 21535   | Continued From pa   | ge 12   | 21535               |   |                               |                          |
|   |   | ot provide justification of why a snot attempted for the a year.  |                     |   |                               |                          |
|   | recommendation w<br>consider if Trazodo<br>The medical record   | armacist provided a hich included "Again - ne dose could be reduced." I lacked any documentation on was followed up on by ician.  |                     |   |                               |                          |
|   | 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. |   |                     |   |                               |                          |
|   | insomnia without an<br>attempting a dose of<br>pharmacist on 2/19<br>facility had not reas<br>determine the resid   | nued on Trazodone for<br>ny justification for not<br>decrease recommended by the<br>/15, 6/18/15, and 9/14/15, the<br>sessed R18's sleep to<br>lent was receiving the<br>nd continued to require the<br>mnia. |                     |   |                               |                          |
|   | Sedative/Hypnotics "Residents who use gradual dose reduce interventions, unles an effort to disconti  | ŭ   |                     |   |                               |                          |
|   |   | armacological Medications and procedure dated 3/15.   |                     |   |                               |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|--|---|---------------------|---|-------------------------------|--------------------------|
|  |  |   | A. BOILDING.        |   |                               |                          |
|  |  | 00019   | B. WING             |   | 11/0                          | 5/2015                   |
| NAME OF I  | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S      | STATE, ZIP CODE   |                               |                          |
| GOOD S   | AMARITAN SOCIETY   | - HOWARD LAKE 413 13TH<br>HOWARD  | AVENUE<br>LAKE, MN  | 55349   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| 21535  | Continued From pa  | ige 13  | 21535               |   |                               |                          |
|  | sedative/hypnotic the beyond the manufaduration of use, the taper the medication contraindicated."   | ong as a resident remains on a nat is used routinely and acturer's recommendations for ecenter should attempt to an quarterly unless clinically |                     |   |                               |                          |
|  | The director of nurs and/or revise facility related to unnecess for use. Responsibly re-educated on the The medication regidentified in the def compliance with the actions taken when documentation coun medication regimer evaluated for lacking appropriate efforts auditing system con implemented, with a Quality Assessment ensure on-going control of the control of th | made toward compliance. An uld be developed and results shared with the facility's t & Assurance committee, to                                  |                     |   |                               |                          |
| 21805  | one (21) days.   | .651 Subd. 5 Patients &   | 21805               |   |                               | 12/15/15                 |
| 21000  | Residents of HC Fa   | ac.Bill of Rights   | 21000               |   |                               | 12/10/10                 |
|  | residents have the courtesy and respe  | us treatment. Patients and right to be treated with ct for their individuality by ersons providing service in a                                 |                     |   |                               |                          |

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | E CONSTRUCTION   | (X3) DATE SURVE<br>COMPLETED |                          |
|---|---|---|---------------------|--|------------------------------|--------------------------|
|   |   | 00019   | B. WING             |  | 11/0                         | 5/2015                   |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY,        | STATE, ZIP CODE  |                              |                          |
| GOOD S  | AMARITAN SOCIETY  | - HOWARDIAKE  | LAKE, MN            | 55349  |                              |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                         | (X5)<br>COMPLETE<br>DATE |
| 21805   | This MN Requirements: Based on observation review the facility facility facility facility for assisted with eating feeding her.  Findings include:  R23's quarterly min 8/27/15, indicated to cognitive impairments assistance with eat cognitive impairments assistance with eat R23's care plan data resident required to drinking.  During observation nursing assistant (NR23 soup, a sandworth Throughout the compuments of 6:10 p.m., NAt 5:40 p.m. NA-K tablemate and stood poured her soup in back by R23, and of feeding her.  During observation to 9:05 a.m. NA-L wR23's room and feed NA-L tossed the spand quickly left R23. | ent is not met as evidenced ion, interview, and document ailed to provide dignified esidents (R23) observed being g by staff who stood while nimum data set (MDS) dated the resident had severe nt and required total staff ting.  Ited 10/12/15, directed staff the otal assistance with eating and on 11/04/15, at 5:31 p.m.  NA)-K was observed feeding vich, and a beverage. Instant observation from 5:31 NA-K stood while feeding R23. Instant observation from 5:31 NA-K stood while feeding R23. Instant observation was observed to the resident and a cup. NA-K then walked continued to stand while on 11/05/15, from 9:00 a.m. In was observed standing in eding her yogurt. At 9:05 a.m., in oon and cup in the garbage, 3's room. | 21805               | corrected  |                              |                          |
|   | while feeding reside  | <ul><li>stated staff should be sitting<br/>ents, however, R23 was, "Very<br/>ould be exploring other options</li></ul>  |                     |  |                              |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |  |  |  | 3) DATE SURVEY<br>COMPLETED |                          |
|--|---|--|--|--|-----------------------------|--------------------------|
|  |   | 00019  | B. WING                                |  | 11/0                        | 5/2015                   |
|  | PROVIDER OR SUPPLIER  AMARITAN SOCIETY  | - HOWARD LAKE 413 13TH   | DRESS, CITY, S<br>HAVENUE<br>DLAKE, MN | STATE, ZIP CODE  |                             |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE                       | (X5)<br>COMPLETE<br>DATE |
| 21805  | such as a different assisting R23 with a 2013, indicated, "The residents in a manneach respites dignit recognition of his ordietary aspects."  SUGGESTED MET The director of nurse and/or revise facility related to dignified a personnel could be and procedures. Condividual(s) identifier reviewed and/or | chair for staff to sit on while eating.  and Procedure dated February ne Center will promote care for her that maintains or enhances y and respect your full repair her individuality regarding.  THOD OF CORRECTION: sing or designee, could review repolicies and procedures dinning services. Responsible re-educated on these policies are practices for the ed in the defliciency could be rised for compliance with supporting documentation residents could be evaluated and services. An auditing veloped and implemented, with the facility's Quality urance committee, to ensure |  |  |                             |                          |
| 21880  | Residents of HC Fa<br>Subd. 20. Grievar<br>shall be encourage<br>their stay in a facility<br>to understand and a<br>patients, residents,  | ac.Bill of Rights  aces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend  | 21880                                  |  |                             | 12/15/15                 |

Minnesota Department of Health

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                      | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|---|--|--|----------------------|--|-------------------|--------------------------|
|   |  | A. BUILDING:   |                      |  |                   |                          |
|   |  | 00019  | B. WING              |  | 11/0              | 5/2015                   |
| NAME OF I   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S       | STATE, ZIP CODE  |                   |                          |
| GOOD S  | AMARITAN SOCIETY   | - HOWARD LAKE  | I AVENUE<br>LAKE, MN | 55349  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | .D BE             | (X5)<br>COMPLETE<br>DATE |
| 21880   | and others of their conterference, coercincluding threat of cogrievance procedur well as addresses a Office of Health Fanursing home ombounded and a conspice of Health Fanursing home ombounded and a conspice of Health Fanursing home ombounded and a conspice of the second of the sec | and services to facility staff choice, free from restraint, ion, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the acility Complaints and the area udsman pursuant to the Older stion 307(a)(12) shall be acuous place.  In inpatient facility, every in as defined in section acute care facility, and every increase than two people that it mental health services shall real grievance procedure that, if forth the process to be time limits, including time ponse; provides for the patient in the assistance of an a written response to written a written response to written ovides for a timely decision by in maker if the grievance is not. Compliance by hospitals, in sas defined in section hospital-based primary in 144.691 and compliance by the organizations with section to be compliance with the written internal grievance | 21880                |  |                   |                          |
|   | by:  | ent is not met as evidenced and document review, the   |                      | corrected  |                   |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|---|--|--|---------------------|---|-------------------|--------------------------|
|   |  | 00019  | B. WING             |   | 11/0              | 5/2015                   |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE   |                   |                          |
| GOOD S  | AMARITAN SOCIETY   | - HOWARD I AKE   | AVENUE<br>LAKE, MN  | 55349   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 21880   | Continued From pa  | ge 17  | 21880               |   |                   |                          |
|   | concerns voiced by   | mptly resolve complaints and family members for 1 of 2 iewed for grievances.   |                     |   |                   |                          |
|   | Findings include:  |  |                     |   |                   |                          |
|   | indicated that she v   | imum Data Set dated 8/27/15,<br>vas moderately cognitively<br>ongestive heart failure (CHF).   |                     |   |                   |                          |
|   | identified they are t<br>and they both and a<br>explained that R12<br>hospitalization for p<br>issues. F-G stated<br>registered nurse (R<br>Lasix (medication u<br>to heart failure) who<br>stay from 09/30/15-<br>that she was unaway | sulmonary and respiratory she had spoken with (N)-A regarding R12's order for used to treat fluid build-up due en R12's return from hospital (10/02/15). The F-G stated are that R12 had not continued was discharged from the                           |                     |   |                   |                          |
|   | director of nursing of stated they were awaregarding R12's La not followed on the and was unsure if FThe administrator sto F-G about the La  | on 11/05/15, at 5:01 p.m. the (DON) and administrator both ware of F-G's concern six. The DON stated she had concern expressed by F-G, RN-A had followed with F-G. stated she also had not spoken asix complaint but maybe is may have spoken to F-G but |                     |   |                   |                          |
|   | with F-G on the ever<br>concerns with R12'<br>hospitalization's. RI  | 0 p.m. RN-A stated she spoke ening of 10/2/15, about her s Lasix order and N-A stated she reviewed the d the DON of F-G's concerns.  |                     |   |                   |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|--|---------------------|--|-------------------------------|--------------------------|
|   |   | 00019  | B. WING             |  | 11/0                          | 5/2015                   |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE  |                               |                          |
| GOOD S  | AMARITAN SOCIETY  | - HOWARD LAKE 413 13TH   | AVENUE<br>LAKE, MN  | 55349  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE | D BE                          | (X5)<br>COMPLETE<br>DATE |
| 21880   | Continued From pa   | ge 18  | 21880               |  |                               |                          |
|   | 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. |  |                     |  |                               |                          |
|   | The director of nurs<br>and/or revise facility<br>related to individual<br>Responsible person<br>these policies and p<br>be addressed for the<br>deficiency, with sup<br>maintained. Other<br>for appropriate resp<br>An auditing system<br>implemented, with   | THOD OF CORRECTION: sing or designee, could review y policies and procedures resident grievances. In could be re-educated on procedures. Grievances could be individual(s) identified in the apporting documentation residents could be evaluated ponse to voiced grievances. could be developed and results shared with the facility's t & Assurance committee, to impliance. |                     |  |                               |                          |

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STATE FORM F5CI11 If continuation sheet 19 of 20

PRINTED: 12/10/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_\_ B. WING \_ 00019 11/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **413 13TH AVENUE GOOD SAMARITAN SOCIETY - HOWARD LAKE HOWARD LAKE, MN 55349** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21880 21880 Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

Minnesota Department of Health