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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GQ54

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00146

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245403**

2.STATE VENDOR OR MEDICAID NO.
(L2) **150518100**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/29/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Gail Anderson Unit Supervisor — 09/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 11/02/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/29/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245403

October 16, 2016

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

Dear Mr. Wolf:

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

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

Effective September 2, 2016 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 12, 2016

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

RE: Project Number S5403025

Dear Mr. Wolf:

On July 28, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 14, 2016. 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 August 29, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 2, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 2, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 14, 2016, effective September 2, 2016 and therefore remedies outlined in our letter to you dated July 28, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.
Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245403 Y1	A. Building B. Wing Y2	8/29/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0282	Correction	ID Prefix F0312	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed
LSC	08/23/2016	LSC	08/23/2016	LSC	08/23/2016
ID Prefix F0313	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.25(b)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	08/23/2016	LSC	08/23/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	GA/mm	09/12/2016	28034	08/29/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245403 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/2/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	09/02/2016	LSC K0029	08/03/2016	LSC K0051	08/03/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0062	08/03/2016	LSC K0141	08/03/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	09/12/2016	36536	09/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245403 (Y1)	A. Building 02 - 2007 CONNECTING LINK B. Wing (Y2)	9/2/2016 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 08/03/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 09/12/2016	**SIGNATURE OF SURVEYOR** 36536	**DATE** 09/02/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 7/12/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GQ54

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00146

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)
13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE NEII
08/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist
08/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 28, 2016

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

RE: Project Number S5403025

Dear Mr. Wolf:

On July 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 23, 2016, 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 August 23, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 14, 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 January 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

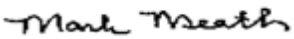
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	07/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide cares to maintain dignity for 1 of 2 residents (R46) reviewed for dignity. Findings include: R46's quarterly Minimum Data Set (MDS) dated 6/1/16 identified R46 had diagnoses which included Alzheimer's disease, abscess and pain. The MDS identified R46 had severe cognitive impairment and required total assistance with all activities of daily living (ADLs).	F 241	1. Resident's (R46) shirt was changed on 7/12/16. 2. All residents who have history of food spillage are identified as having the potential to be affected by this same deficient practice. Education to be provided to all staff by Director of Nursing, Social Services Director, or designee regarding resident appearances and changing clothing when necessary, keeping residents tidy and clean at all times. 3. The Director of Nursing, Social	8/23/16

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

Electronically Signed | 08/03/2016

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

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F 241	Continued From page 1 R46's care plan dated 6/9/16 identified R46 was unable to communicate her needs, was totally dependent on staff for dressing and required staff assistance with personal hygiene. On 7/12/16, at 2:45 p.m. R46 was seated in her wheelchair, in the lounge of the facility, in front of the television. Two other residents were seated in the area, and staff and residents were observed to walk past R46 seated in the lounge. R46 wore a blue and white striped shirt and had a approximately 3 inches (in.) long by 3 in. wide area on the front of her shirt extending from her collar which was covered with a crusted white substance. The area appeared dry, and stiff in appearance. On 7/12/16, at 3:33 p.m. R46 was seated in her wheelchair in her room. The same soiled shirt was observed to be worn by R46. On 7/12/16, at 3:49 p.m. nursing assistant (NA-A) confirmed the soiled area on R46's shirt and stated he felt it was probably melted ice cream on the shirt, from food R46 had eaten earlier in the day. On 7/14/16, at 9:55 a.m. NA-B stated R46 had severe cognitive impairment and was dependent on staff for cares. She stated if any residents clothes became dirty, at any time their clothes should be changed. She stated sometimes R46 dribbled food out of her mouth. NA-B stated she felt there was no reason for R46 to have dirty clothes on because she wore a clothing protector at meals and was assisted to eat by facility staff. On 7/14/16, at 10:05 a.m. NA-C stated R46 was dependent on staff for cares, and stated she felt	F 241	Services Director, or designee, will provide dignity training to all staff on August 9th and 10th, 2016. Staff will continue to be educated on resident rights and dignity upon hire and annually thereafter. 4. To monitor performance and to ensure sustainability, the Director of Nursing, Social Services Director, or designee, will perform clothing spot checks daily for resident #46 and random other residents x4 weeks, then randomly x3 weeks. All audit findings will be reported to the monthly QA meeting for further recommendation. 5. Completion Date: August 23, 2016	

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F 241	Continued From page 2 R46's cognition wasn't that bad. She stated if a resident's clothes were visibly dirty they should be changed right away. She stated R46's food was mixed with milk and fed to her and sometimes food got on R46's clothes. On 7/14/16, at 10:34 a.m. licensed practical nurse (LPN-A) stated R46 was fed by staff, had severe cognitive impairment and was totally dependent on staff for all cares. She stated resident clothes should be changed when they are dirty or when food is spilled on them. She stated she when she feeds residents crushed medications in food she got some food on their shirts. LPN-A stated R46 wore a clothing protector but food got around it. On 7/14/16, at 12:36 p.m. clinical manager (CM)-A stated R46 had severe cognitive impairment and was totally dependent on staff for cares. She stated she expected resident's clothes be changed in the morning, at bedtime and routinely if soiled. She stated R46's shirt should have been changed when her shirt became soiled with food. On 7/14/16, at 2:48 p.m. director of nursing confirmed R46 had severe cognitive impairment and was totally dependent on staff for care. She stated to maintain R46's dignity she expected staff to ensure R46's clothes were clean and for R46 to look her best. Review of the facility policy, Resident Dignity identified the facility promoted care for the residents in a manner and environment that maintained or enhanced each resident's dignity and respect in full recognition of their individuality.	F 241		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		8/23/16

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F 282 SS=D	Continued From page 3 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the plan of care for 1 of 1 resident (R46) reviewed for activities of daily living (ADLs) and 1 or 1 residents (R40) reviewed with a change in hearing abilities. Findings include: R46's care plan dated 6/9/16 identified R46 had a self care deficit related to dementia and left hip prosthesis removal. The care plan identified R46 required staff assistance with personal hygiene and preferred staff to shave her facial hair. On 7/11/16, at 2:26 p.m. R46 was in her wheelchair in the lounge area in front of the TV with visitors and other residents in the area. R46 had approximately 20 long, gray, course hairs on her chin and 1 very long gray, curled hair on her upper lip. On 7/12/16, at 3:33 p.m. R46 was in her wheelchair in her room with NA-A. The long, gray hairs remained on her chin and upper lip. NA-A stated R46 was waiting for the nurse to assess R46's pain. On 7/13/16, at 9:50 a.m. R46 was in her	F 282	1. Resident's (R46) facial hair was shaved 7/14/16. 2. All female residents within the facility who require assistance with shaving are identified as having the potential to be affected by this deficient practice. These residents will be reviewed to ensure care plan is updated to reflect this need. 3. The Director of Nursing, Social Services Director, or designee, will provide training to all staff on August 9th and 10th of 2016, specifically reinforcing the use of the Kardex to determine resident need. Staff will continue to be educated on PCC, resident rights and dignity upon hire. 4. To monitor performance and to ensure sustainability, the Director of Nursing, Social Services Director, or designee, will perform audits to ensure resident #46 and other random residents are clean shaven as appropriate, auditing 5x/week x4 weeks, then randomly x3 weeks. All audit findings will be reported to the monthly QA meeting for further recommendation. 5. Completion Date: August 23, 2016 1. Resident (R40) was offered an	

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F 282	Continued From page 4 wheelchair in the lounge area with 2 other residents in front of the television. R36 continued to have the long, gray hairs observed on her chin and upper lip. On 7/14/16, at 9:55 a.m. NA-B stated R46 had severe cognitive impairment and was dependent on staff for cares. She stated R46 should be shaved on bath days. She stated she noticed R46 should have been shaved yesterday but she got busy and forgot. She stated she wasn't sure how long its been since R46 had been shaved, but stated she felt R46 really needed it. On 7/14/16, at 12:36 p.m. clinical manager (CM-A) stated R46 had severe cognitive impairment and was totally dependent on staff for cares. She stated the facility asked residents on admission about their individual shaving preference. She stated shaving was a part of routine care and expected staff to shave residents as needed. She stated R46 wanted to be shaved but was not aware it was care planned for staff to shave her. She stated she would expect the bath aide and NA's to shave R46 as needed. On 7/14/16, at 2:48 p.m. director of nursing stated R46 had severe cognitive impairment and was totally dependent on staff for care. DON stated normally the bath aide took care of shaving residents but stated she was on vacation and she must have gotten missed. She stated staff knew they should removed R46's facial hair and R46 would always look her best. Review of R40's care plan revised 6/4/14,	F 282	appointment on August 2nd 2016 to have her hearing re-tested and assessed but she refused this. Resident continues to be assessed quarterly and will be continue to be offered audiology appointments in case she changes her mind. 2. All care plans and documentation will be reviewed of all residents with hearing deficits within the facility to ensure that their hearing has been assessed and audiology appointments have been offered. Care plans reflect to the Kardex which gives direction to staff for use of hearing assistive devices. 3. The Director of Nursing, Social Services Director, or designee, will provide training to all staff on August 9th and 10th, 2016, specifically reinforcing the use of the Kardex to determine resident need. Staff will continue to be educated on PCC, resident rights and dignity upon hire. 4. To monitor performance and to ensure sustainability, the Director of Nursing, Social Service Director, or designee, will perform audits 5x/week x4 weeks, then randomly x3 weeks. All audit findings will be reported to the monthly QA meeting for further recommendation. 5. Completion Date: August 23, 2016	

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F 282	Continued From page 5	F 282		

identified R40 was hard of hearing, directed staff to monitor effectiveness of hearing amplifier and to ensure devices functioning and availability.

On 7/12/16, at 1:14 p.m. R40 was seated in a chair in the dining room, R40 did not have a hearing amplifier in place. Nursing assistant (NA)-F spoke to R40 with a raised voice and asked R40 if she wanted to go back to her room. R40 stood from the chair and took a hold of her 4 wheeled walker and NA-F walked next to R40 back to her room. While walking in the hallway towards R40's room, NA-F spoke to R40 with a raised voice towards her left ear and asked R40 what she planned on doing for the rest of the day. R40 replied she did not know. NA-F then stated to R40 that the facility had hymn singing for an activity commented to R40, "but you can't hear it can you?," that's too bad you used to love going to hymn music." R40 did not respond to NA-F and walked to her room and sat in a rocker chair. R40's hearing amplifier was observed to be in a charging station on the side table in her room.

On 7/13/16, at 7:05 a.m. R40 was seated in her rocker chair in her room. R40's hearing amplifier was observed to be in the charging station on the side table in her room, on the right of her rocker chair.

On 7/13/16, at 8:17 a.m. R40 walked to the dining room with her 4 wheeled walker with NA-B walking next to her on R40's right side. NA-G assisted R40 to a seated position on a chair in the dining room. NA-G stood behind R40 and explained to her where on the tray her fluids were placed. R40 was not observed to react to NA-G's instructions. NA-F brought R40's plate to her and spoke into R40's left ear with a raised voice and

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F 282	Continued From page 6	F 282		

explained to her where on her plate her foods were located and handed R40 a spoon. R40 was not observed to react to NA-F's instructions and felt around on the tray for her foods and felt for her cups of fluids. R40 did not converse or interact with either of the two tablemate's or staff throughout the breakfast meal. R40 was not wearing her hearing amplifier at any time during the observation.

On 7/14/16, at 1:04 p.m. R40 was seated in a chair in the dining room eating the noon meal. R40 wore her hearing amplifier and was conversing with staff seated at another table.

On 7/12/16, at 2:37 p.m. R40 was seated in her room, in a rocker chair. On the right of the rocker chair was a side table which held a charging station and a hearing amplifier with headphones. While seated close to R40 and speaking directly into R40's left ear, R40 stated her days consisted of the same thing everyday, eating meals and sitting in her room. R40 stated she used to attend the music events at the facility but could not anymore due to her poor hearing. R40 stated her hearing had been gradually declining the past few months. R40 stated she used to wear a hearing aid and then used a headphone device which did not seem to help anymore. R40 stated she felt the staff were not aware she could not hear them, but was used to it. R40 stated she felt her days ran together and she often slept through most of her days. R40 stated she felt it was hard to carry on a conversation with others at times because of her poor hearing and felt others may get impatient with her. R40 further stated facility staff would come and talk to her once in a while for a few minutes, never more than a couple of minutes and did get lonely at times. R40 stated

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F 282	Continued From page 7	F 282		

she used to love going to music events at the facility, but could no longer hear the music and was not able to attend group activities due to her poor hearing.

On 7/13/16, at 11:49 a.m. activity director (AD) confirmed R40 had hearing impairment and no longer attended musical activities due to her poor hearing. AD stated R40 used to listen to talking books or the radio in her room, but had stopped since the beginning of the year. AD stated R40 received 1:1 visits from an activity aid three times a week and would generally run 10-15 minutes. AD stated she was not aware R40 was no longer wearing her hearing amplifier.

On 7/13/16, registered nurse (RN)-A confirmed R40 was very hard of hearing and required assistive devices to aid in hearing. RN-A stated R40 should wear her hearing amplifier during waking hours and was able to place the amplifier on her ears independently. RN-A stated she was unaware R40 was no longer wearing the hearing amplifier though had expected staff to notify her when R40 stopped wearing the hearing amplifier. RN-A stated hearing assessment were completed quarterly with the MDS and as needed with changes. RN-A confirmed R40's hearing was last assessed with last MDS, back in May of 2016.

On 7/13/16, at 12:23 p.m. licensed practical nurse (LPN)-B stated R40 had not been routinely wearing her hearing amplifier and had stopped wearing the amplifier the previous week. LPN-B stated she was not sure why R40 stopped using the amplifier and confirmed she did not notify RN-A of R40 not utilizing the amplifier.

On 7/13/16, at 9:43 a.m. NA-F stated R40's

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F 282	Continued From page 8 overall status had been changing since last winter and R40 needed more assistance with ADL's such as dressing and grooming. NA-F stated R40 was very hard of hearing and had a hearing amplifier to use when she wanted to. NA-F stated R40 sometimes used the amplifier for lunch and was able to use it as she wanted. NA-F stated R40 no longer went to activities due to her hearing loss. NA-F stated she could not recall the last time she saw R40 using the amplifier and confirmed she had not offered R40 the use of the amplifier. On 7/14/16, at 10:18 a.m. social service director (SS) stated she had felt R40's hearing had changed again based on R40 remaining in her room. SS stated she was not aware R40 was not using the hearing amplifier and was not attending music groups. SS stated she felt R40 would benefit form frequent 1:1 visits to prevent increase in isolation. On 7/14/16, at 1:18 p.m. the director of nursing (DON) stated she would expect her staff to notice when R40 stopped wearing the hearing amplifiers and would expect R40's hearing to be re-assessed if any changes were observed or reported by R40. The DON stated she expected R40's care plan to be followed and staff to assist with hearing devices as needed or directed.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		8/23/16

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F 312	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide grooming services for 1 of 1 residents (R46) reviewed for activities of daily living (ADLs). Findings include: R46's quarterly Minimum Data Set (MDS) dated 6/1/16 identified R46 had diagnoses which included Alzheimer's disease, abscess and pain. The MDS identified R46 had severe cognitive impairment and required total assistance with all activities of daily living (ADLs). R46's care plan dated 6/9/16 identified R46 had a self care deficit related to dementia and left hip prosthesis removal. The care plan identified R46 required staff assistance with personal hygiene and preferred staff to shave her facial hair. On 7/11/16, at 2:26 p.m. R46 was in her wheelchair in the lounge area in front of the TV with visitors and other residents in the area. R46 had approximately 20 long, gray, course hairs on her chin and 1 very long gray, curled hair on her upper lip. On 7/12/16, at 3:33 p.m. R46 was in her wheelchair in her room with NA-A. The long, gray hairs remained on her chin and upper lip. NA-A stated R46 was waiting for the nurse to assess R46's pain. On 7/13/16, at 9:50 a.m. R46 was in her wheelchair in the lounge area with 2 other	F 312	1. Resident's (R46) facial hair was shaved 7/14/16. 2. All female residents within the facility who require assistance with shaving are identified as having the potential to be affected by this same deficient practice. These residents will be reviewed to ensure care plan is updated to reflect this need. 3. The Director of Nursing, Social Services Director, or designee, will provide training to all staff on August 9th and 10th of 2016, specifically reinforcing the use of the Kardex to determine resident need. Staff will continue to be educated on PCC, resident rights and dignity upon hire. 4. To monitor performance and to ensure sustainability, the Director of Nursing, Social Services Director, or designee, will perform audits to ensure resident #46 and other random residents are clean shaven as appropriate, auditing 5x/week x4 weeks, then randomly x3 weeks. All audit findings will be reported to the monthly QA meeting for further recommendation. 5. Completion Date: August 23, 2016	

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F 312	Continued From page 10	F 312		

residents in front of the television. R36 continued to have the long, gray hairs observed on her chin and upper lip.

On 7/14/16, at 9:55 a.m. NA-B stated R46 had severe cognitive impairment and was dependent on staff for cares. She stated R46 should be shaved on bath days. She stated she noticed R46 should have been shaved yesterday but she got busy and forgot. She stated she wasn't sure how long its been since R46 had been shaved, but stated she felt R46 really needed it.

On 7/14/16, at 10:05 a.m. NA-C stated R46 was dependent on staff for cares, and stated she felt R46's cognition wasn't that bad. She stated R46's facial hair was long and she needed to be shaved. She stated she didn't know when R46 was shaved last but stated she needed it.

On 7/14/16, at 10:34 a.m. licensed practical nurse (LPN-A) stated R46 had severe cognitive impairment and was totally dependent on staff for all cares. She stated she expected R46 to be shaved on bath days, and daily if facial hair was noticed. She stated hopefully the bath aide shaved her once a week. She stated no one should ever have whiskers. She stated she didn't think R46 had problems with facial hair, but couldn't be sure.

On 7/14/16, at 12:36 p.m. clinical manager (CM-A) stated R46 had severe cognitive impairment and was totally dependent on staff for cares. She stated the facility asked residents on admission about their individual shaving preference. She stated shaving was a part of routine care and expected staff to shave residents as needed. She stated R46 wanted to

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	245403	A. BUILDING _____ B. WING _____	07/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 11 be shaved but felt it was not care planned for staff to shave her. She stated she would expect the bath aide and NA's to shave R46 as needed. On 7/14/16, at 2:48 p.m. director of nursing stated R46 had severe cognitive impairment and was totally dependent on staff for care. DON stated normally the bath aide took care of shaving residents but stated she was on vacation and she must have gotten missed. She stated staff knew they should removed R46's facial hair and R46 would always look her best. Review of the facility policy, ADLs identified any resident who is unable to carry out ADLs will receive the necessary care and services to maintain grooming and personal hygiene.	F 312		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper care was provided which included reassessment of hearing abilities and devices for 1 of 1 residents (R40) who experienced a decrease in hearing	F 313	1. Resident (R40) was offered an appointment on August 2nd 2016 to have her hearing re-tested and assessed but she refused this. Resident continues to be assessed quarterly and will be continue to	8/23/16

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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F 313	Continued From page 12 abilities. Findings include: Review of R40's quarterly Minimum Data Set (MDS) dated 5/4/16, identified R40 was cognitively intact and had diagnoses which included anxiety, depression and legal blindness. The MDS identified R40 had moderate difficulty hearing, used a hearing device and required extensive assistance from staff for activities of daily living (ADL's.) Review of R40's communication Care Area Assessment (CAA) dated 11/20/15, identified R40 had a history of hearing loss and had complaints of increased difficulty hearing and used a hearing amplifier. The CAA identified R40 required staff assistance with placement and maintenance of the hearing amplifier. The CAA further identified R40 had reported she did not hear as well as she used to and had impacted cerum at the time of the assessment which required treatment. Review of R40's care plan revised 6/4/14, identified R40 was hard of hearing, directed staff to monitor effectiveness of hearing amplifier and to ensure devices functioning and availability. Review of R40's care conference note dated 5/17/16, revealed R40 was hard of hearing and required to the use of a hearing amplifier. Review of R40's physician progress note dated 5/22/16, noted a review of systems by R40's physician assistance which revealed R40 had complaints of hearing loss and was to use a hearing amplifier.	F 313	be offered audiology appointments in case she changes her mind. 2. All care plans and documentation will be reviewed of all residents with hearing deficits within the facility to ensure that their hearing has been assessed and audiology appointments have been offered. Care plans reflect to the kardex which gives direction to staff for use of hearing assistive devices. 3. The Director of Nursing, Social Services Director, or designee, will provide training to all staff on August 9th and 10th, 2016, specifically reinforcing the use of the kardex to determine resident need. Staff will continue to be educated on PCC, resident rights and dignity upon hire. 4. To monitor performance and to ensure sustainability, the Director of Nursing, Social Services Director, or designee, will perform audits 5x/week x4 weeks, then randomly x3 weeks. All audit findings will be reported to the monthly QA meeting for further recommendation. 5. Completion Date: August 23, 2016	

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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On 7/12/16, at 1:14 p.m. R40 was seated in a chair in the dining room, R40 did not have a hearing amplifier in place. Nursing assistant (NA)-F spoke to R40 with a raised voice and asked R40 if she wanted to go back to her room. R40 stood from the chair and took a hold of her 4 wheeled walker and NA-F walked next to R40 back to her room. While walking in the hallway towards R40's room, NA-F spoke to R40 with a raised voice towards her left ear and asked R40 what she planned on doing for the rest of the day. R40 replied she did not know. NA-F then stated to R40 that the facility had hymn singing for an activity commented to R40, "but you can't hear it can you?," that's too bad you used to love going to hymn music." R40 did not respond to NA-F and walked to her room and sat in a rocker chair. R40's hearing amplifier was observed to be in a charging station on the side table in her room.

On 7/13/16, at 7:05 a.m. R40 was seated in her rocker chair in her room. R40's hearing amplifier was observed to be in the charging station on the side table in her room, on the right of her rocker chair.

On 7/13/16, at 8:17 a.m. R40 walked to the dining room with her 4 wheeled walker with NA-B walking next to her on R40's right side. NA-G assisted R40 to a seated position on a chair in the dining room. NA-G stood behind R40 and explained to her where on the tray her fluids were placed. R40 was not observed to react to NA-G's instructions. NA-F brought R40's plate to her and spoke into R40's left ear with a raised voice and explained to her where on her plate her foods were located and handed R40 a spoon. R40 was not observed to react to NA-F's instructions and felt around on the tray for her foods and felt for

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F 313	Continued From page 14	F 313		

her cups of fluids. R40 did not converse or interact with either of the two tablemate's or staff throughout the breakfast meal. R40 was not wearing her hearing amplifier at any time during the observation.

On 7/14/16, at 1:04 p.m. R40 was seated in a chair in the dining room eating the noon meal. R40 wore her hearing amplifier and was conversing with staff seated at another table.

On 7/12/16, at 2:37 p.m. R40 was seated in her room, in a rocker chair. On the right of the rocker chair was a side table which held a charging station and a hearing amplifier with headphones. While seated close to R40 and speaking directly into R40's left ear, R40 stated her days consisted of the same thing everyday, eating meals and sitting in her room. R40 stated she used to attend the music events at the facility but could not anymore due to her poor hearing. R40 stated her hearing had been gradually declining the past few months. R40 stated she used to wear a hearing aid and then used a headphone device which did not seem to help anymore. R40 stated she felt the staff were not aware she could not hear them, but was used to it. R40 stated she felt her days ran together and she often slept through most of her days. R40 stated she felt it was hard to carry on a conversation with others at times because of her poor hearing and felt others may get impatient with her. R40 further stated facility staff would come and talk to her once in a while for a few minutes, never more than a couple of minutes and did get lonely at times. R40 stated she used to love going to music events at the facility, but could no longer hear the music and was not able to attend group activities due to her poor hearing.

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F 313	Continued From page 15 On 7/13/16, at 11:49 a.m. activity director (AD) confirmed R40 had hearing impairment and no longer attended musical activities due to her poor hearing. AD stated R40 used to listen to talking books or the radio in her room, but had stopped since the beginning of the year. AD stated R40 received 1:1 visits from an activity aid three times a week and would generally run 10-15 minutes. AD stated she was not aware R40 was no longer wearing her hearing amplifier. On 7/13/16, registered nurse (RN)-A confirmed R40 was very hard of hearing and required assistive devices to aid in hearing. RN-A stated R40 should wear her hearing amplifier during waking hours and was able to place the amplifier on her ears independently. RN-A stated she was unaware R40 was no longer wearing the hearing amplifier though had expected staff to notify her when R40 stopped wearing the hearing amplifier. RN-A stated hearing assessment were completed quarterly with the MDS and as needed with changes. RN-A confirmed R40's hearing was last assessed with last MDS, back in May of 2016. RN-A confirmed R40's care plan directed staff to monitor the use of the hearing amplifier. On 7/13/16, at 12:23 p.m. licensed practical nurse (LPN)-B stated R40 had not been routinely wearing her hearing amplifier and had stopped wearing the amplifier the previous week. LPN-B stated she was not sure why R40 stopped using the amplifier and confirmed she did not notify RN-A of R40 not utilizing the amplifier. On 7/13/16, at 9:43 a.m. NA-F stated R40's overall status had been changing since last winter and R40 needed more assistance with ADL's	F 313		

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F 313	Continued From page 16 such as dressing and grooming. NA-F stated R40 was very hard of hearing and had a hearing amplifier to use when she wanted to. NA-F stated R40 sometimes used the amplifier for lunch and was able to use it as she wanted. NA-F stated R40 no longer went to activities due to her hearing loss. NA-F stated she could not recall the last time she saw R40 using the amplifier and confirmed she had not offered R40 the use of the amplifier. On 7/14/16, at 10:18 a.m. social service director (SS) stated she had felt R40's hearing had changed again based on R40 remaining in her room. SS stated she was not aware R40 was not using the hearing amplifier and was not attending music groups. SS stated she felt R40 would benefit form frequent 1:1 visits to prevent increase in isolation. On 7/14/16, at 1:18 p.m. the director of nursing (DON) stated she would expect her staff to notice when R40 stopped wearing the hearing amplifiers and would expect R40's hearing to be re-assessed if any changes were observed or reported by R40. The DON stated she expected R40's care plan to be followed and staff to assist with hearing devices as needed or directed. Review of a facility policy and procedure titled, Communicating Information to Persons with Sensory Impairment, revised 3/16, identified persons with hearing impairments were to have an individualized assessment to guide staff on appropriate interventions.	F 313		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		8/23/16

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F 465	Continued From page 17 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident care equipment was maintained to ensure safety and operation for 1 of 1 residents (R36) who utilized a front wheeled walker. Findings include: R36's Significant Change Minimum Data Set, dated 4/27/16, identified R36 had diagnoses which included arthritis, anxiety and depression. The MDS identified R36 was cognitively intact and required supervision and assistance with walking. R36's care plan dated 5/1/16 identified R36 had limited physical mobility due to osteoarthritis and macular degeneration and required a front wheeled walker with occasional stand-by assistance for ambulation. On 7/11/16, at 6:12 p.m. R36 ambulated out of the dining room after supper and walked down the hallway towards his room using his walker and nursing assistant (NA)-D was at his side. The front legs of R36's walker had gray, hard plastic ends which enclosed around bright yellow tennis balls. R36's wheels of the walker dragged on the floor, and the wheels did not turn/roll easily and vibrated very loudly down the length of hallway.	F 465	1. Resident's (R36) walker was cleaned, front wheels were greased and new tennis balls were placed 7/15/16. 2. All residents within the facility who use walkers are identified as having the potential to be affected by the same deficient practice. All walkers will be inspected monthly to ensure they are clean and in good repair. 3. The Director of Maintenance, Environmental Services Director, or designee, will provide education related to this issue to all maintenance staff on August 9th and 10th, 2016. Maintenance staff will continue to be educated on this process upon hire. The Director of Nursing, Social Services Director, or designee, will provide education to all nursing staff on August 9th and 10th, 2016, related to this issue, ensuring day to day cleanliness of resident's walker. Nursing staff will continue to be educated on this process upon hire. 4. To monitor performance and to ensure sustainability, the Director of Maintenance, the Environmental Services Director, or designee, will perform audits weekly x4, then monthly x2. All audit findings will be reported to the monthly QA meeting for further recommendation. 5. Completion Date: August 23, 2016	

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F 465	Continued From page 18	F 465		

On 7/13/16, at 8:30 a.m. R36 was observed to ambulate out the dining room, with his walker. R36 could only make hesitant steps behind the walker while the front wheels of R36's walker appeared to be sticking on the floor, at times jumping or not rolling at all. The wheels of the walker made loud rubbing noises and vibrating noises as he left the dining room.

On 7/14/16, at 12:13 p.m. R36 stated something was wrong with the back end of his walker. He stated the walker made it hard for him to walk sometimes. He stated it vibrated and rattled and made noise. R36 stated he told staff it didn't work, and it hadn't worked for quite awhile. He stated a staff person had looked at his walker in the past, but the walker was still wasn't working correctly.

On 7/14/16, at 12:19 p.m. R36 walked from his room to his seat in the dining room for lunch. R36's walker made loud noises and his walker wheels didn't turn. R36's walker dragged the entire way. NA-E passed by R36 on his way and stated "did that wake you up?" and laughed. NA-E continued down the hallway and R36 continued to drag walker to his room.

On 7/14/16, at 12:28 p.m. NA-C stated R36's walker was "pretty squeaky". She stated she was aware of this in the past and asked him if he could hear the noise from the walker. She stated R36 was extremely hard of hearing and stated R36 told her he could even hear the noise. She stated she didn't know if anyone had attempted to repair R36's walker or not.

On 7/14/16, at 12:36 p.m. clinical manager (CM-A) stated she just grabbed R36's walker and

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sprayed the wheels with WD40(lubricant) a few weeks ago and stated she thought it would be ok. She stated she wasn't aware R36's walker was still not fixed. She stated the director of building operations and maintenance (DBOM) was responsible for repair and maintenance of resident walkers.

On 7/14/16, at 12:56 p.m. DBOM stated he was not aware R36's walker had not been working, and indicated he had not seen R36 use his walker.

On 7/14/16, at 1:13 p.m. DBOM stated R36's walker wasn't good. He confirmed the loud noise and stated he felt the tennis balls were worn and didn't roll like they should. He stated the tennis balls needed to be replaced on R36's walker and would get him new ones. He confirmed the walker R36 utilized was a facility owned walker and they repaired and replaced facility owned walkers.

On 7/14/16, at 2:48 p.m. DON stated stated yesterday she heard R36 coming down the hallway before she seen him because his walker was really noisy. She stated she felt maybe the tennis balls were off. She stated she talked to DBOM yesterday and stated she just assumed he fixed it. She stated she expected staff to identify and repair walkers as needed. She stated all staff should be on alert for equipment which needed repair and staff should communicate work orders to maintenance in writing or verbally and then maintenance should let everyone know after its fixed.

On 7/14/16, at 3:30 p.m. DBOM provided the manufacturer's instructions for mobility aids on how to conduct a wheelchair inspection. DBOM

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F 465	Continued From page 20 stated this is what they used for their maintaining resident care equipment policy and confirmed he had not repaired the walker in the recent past.	F 465		

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	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2016**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/04/2016

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

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/12/2016**

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

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K 000	Continued From page 2 addition was added to the east of the south east wing and was determined to be Type II (111) construction. The building is divided into 3 smoke compartments by 30 minute rated fire barriers. The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition), that is monitored for automatic fire department notification. Additional automatic fire detection is provided in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 55 beds with a census of 53 residents at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the	K 018		9/2/16

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K 018	Continued From page 3 door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 2 sets of corridor doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 17 of the 53 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 8:30 am to 1:30 pm on 07/12/2016 observations and staff interview revealed the corridor doors on the clean linen rooms located across from resident rooms 301 and 105 did not positively latch. This deficient condition was verified by the Maintnenance Engineer.	K 018	Doors to the identified clean linen rooms will be replaced with a positive latching hardware that will not require employee assistance to close. Completion Date:September2,2016 Facility Maintenance Director will have monitoring of this system on the Preventative Maintenance Audit for monthly review.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		8/3/16

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K 029	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in 1 of the hazardous rooms in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 17 of the 53 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:30 pm on 07/12/2016 observations and staff interview revealed the oxygen storage room across from resident room 109 did not have a door closer. This deficient condition was verified by the Maintenance Engineer.	K 029	Director of Maintenance will install a door closing device on this door. The device will be monitored routinely through the facility. Preventative Maintenance process will give a report at the facility quarterly QAPI meetings. Completion Date: August 3, 2016	
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically	K 051		8/3/16

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K 051	Continued From page 5 activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 19.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of staff. Findings include: On the facility tour between 8:30 am to 1:30 pm on 07/12/2016 observations and staff interview revealed the smoke detector in the kitchen was within 36 inches of an HVAC supply diffuser. This deficient condition was verified by the Maintenance Engineer.	K 051	The identified smoke detectors have been moved to assure compliance with the NFPA 101 Life Safety Code. An electrical contractor has been retained to make the changes. Completion Date: August 3, 2016	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Base on observatons and interview with staff, the facility has failed to properly maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire	K 062	The facility Maintenance Director will install a escutcheon at the identified sprinkler head. Completion Date: August 3, 2016	8/3/16

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K 062	Continued From page 6 sprinkler system would function properly and in the event of a fire and could negatively affect, an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:30 pm on 07/12/2016 observations and staff interview revealed an escutcheon missing from a sprinkler head in a storage closet located next to the staff lounge. This deficient condition was verified by the Maintenance Engineer.	K 062		
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to comply with the smoking regulation when oxygen is in use. The proper signage was not in place as listed in NFPA 101 (00) Life Safety Code section 19.7.4. This deficient practice could negatively affect 8 of the 53 residents and an undetermined amount of staff and visitors. Findings Include: On the facility tour between 8:30 am to 1:30 pm on 07/12/2016 observations and staff interview revealed a no smoking oxygen in use sign	K 141	The facility Maintenance Director will install a escutcheon at the identified sprinkler head. Completion Date: August 3, 2016	8/3/16

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K 141	Continued From page 7 missing from an exit door outside of the therapy room. This deficient practice was verified by the Maintenance Engineer.	K 141		

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	245403	A. BUILDING **02 - 2007 CONNECTING LINK** B. WING _____	**07/12/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Battle Lake 02 (16 and 8 bed additions) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/04/2016

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

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

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K 000	Continued From page 2 addition was added to the east of the south east wing and was determined to be Type II (111) construction. The building is divided into 3 smoke compartments by 30 minute rated fire barriers. The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition), that is monitored for automatic fire department notification. Additional automatic fire detection is provided in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 55 beds with a census of 53 residents at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain 1 of three exterior exit doors in accordance with NFPA 101 Life Safety Code (00) edition, Section 7.2.1.6.1 delayed egress. During an evacuation this deficient practice could affect 18 of the 53 residents and an undtermined amount of staff and visitors.	K 038	Facility Maintenance Director will acquire and install appropriate signage on noted door. Completion Date: August 3, 2016	8/3/16

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K 038	Continued From page 3 Findings include: On the facility tour between 8:30 am to 1:30 pm on 07/12/2016 observations and staff interview revealed a delayed egress sign was missing from an exit door in the Fisherman's wing. This deficient condition was verified by the Maintenance Engineer.	K 038		