#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

		ICARE/MEDICA ` I - TO BE COM						D: GQ54 Facility ID: 00146
<ol> <li>MEDICARE/MEDICAID PROVIDER N (L1) 245403</li> <li>STATE VENDOR OR MEDICAID NO. (L2) 150518100</li> </ol>	NO.	3. NAME AND ADI (L3) GOOD SAMA (L4) 105 GLENHA (L5) BATTLE LA	ARITAN SOCIET AVEN DRIVE			56515	<ol> <li>TYPE OF ACTION:</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> </ol>	<u>7 (</u> L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW: (L9)		7. PROVIDER/SUP 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7 13 PTIP	) 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 08/29 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>9/2016</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 12/31	DATE: (L35)
11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF         18/19 SNF         55         (L37)         16. STATE SURVEY AGENCY REMARK	19 SNF (L39)	B. Not in Compli Requirements a ICF (L42)	nce With quirements Based On: .cceptable POC iance with Program and/or Applied Waive IID (L43)	15:	2. Tech 3. 24 H 4. 7-D	hnical Personnel Hour RN ay RN (Rural SNF) Safety Code <u>A</u> MEETS	Following Requirements: 6. Scope of Servi 7. Medical Direc 8. Patient Room S 9. Beds/Room (L12) (L15)	ices Limit tor
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY API	PROVAL	Date:
17. surveyor signature Gail Anderson Unit	Supervisor		09/12/2016	(1.19)			proval , <b>Enforcement Specia</b>	alist 11/02/2016
	1			(L19) GIONAL	Mark	Meath	, Enforcement Specia	
	PART II - TO Y rticipate	BE COMPLETEI 20. COM		GIONAL	Mark OFFICE OR 21. 1. 2.	SINGLE STAT	, Enforcement Specia	alist 11/02/2016 (L20)
Gail Anderson Unit	PART II - TO Y rticipate (L21)	BE COMPLETEI 20. COM RIGH	D BY HCFA RE PLIANCE WITH CI ITS ACT:	GIONAL	21. 1. 3.	SINGLE STAT Statement of Financi Ownership/Control I Both of the Above :	, Enforcement Specia E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)
Gail Anderson Unit (	PART II - TO Y rticipate (L21) 23. LTC AGREEMI BEGINNING	BE COMPLETEI 20. Com Righ	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN ENDING DATE	GIONAL VIL	21. 1. 2. 3. 26. TERMINA VOLUNTARY 01-Merger, Close	SINGLE STAT Statement of Financi Ownership/Control I Both of the Above : TION ACTION: _00	, Enforcement Specia E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA 	A-1513) L30)
Gail Anderson Unit : 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24) 25. LTC EXTENSION DATE:	PART II - TO Y rticipate (L21) 23. LTC AGREEMI BEGINNING (L41) 27. ALTERNATIVI A. Suspension o	BE COMPLETED 20. COM RIGH ENT 2 DATE E SANCTIONS of Admissions:	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEME	GIONAL VIL	21. 1. 2. 3. 26. TERMINA VOLUNTARY 01-Merger, Closs 02-Dissatisfaction	SINGLE STAT Statement of Financi Ownership/Control I Both of the Above : TION ACTION: 00 ure n W/ Reimbursemen intary Termination	, Enforcement Specia E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA 	alist       11/02/2016         (L20)         (L20)         (L20)         (L20)         (L30)         (XATY)         eet Health/Safety
Gail Anderson Unit 3	PART II - TO Y rticipate (L21) 23. LTC AGREEMI BEGINNING (L41) 27. ALTERNATIVI	BE COMPLETED 20. COM RIGH ENT 2 DATE E SANCTIONS of Admissions:	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEI ENDING DATE (L25)	GIONAL VIL	COFFICE OR 21. 1. 2. 3. 26. TERMINA VOLUNTARY 01-Merger, Closs 02-Dissatisfactio 03-Risk of Involu	SINGLE STAT Statement of Financi Ownership/Control I Both of the Above : TION ACTION: 00 ure n W/ Reimbursemen intary Termination	, Enforcement Specia E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA (1) (1) (1) (1) (1) (1) (1) (1)	L30) X-1513) L30) XARY eet Health/Safety eet Agreement
Gail Anderson Unit : 19. DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Par 2. Facility is not Eligible 22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24) 25. LTC EXTENSION DATE:	PART II - TO Y rticipate (L21) 23. LTC AGREEMI BEGINNING (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	BE COMPLETED 20. COM RIGH ENT 2 DATE E SANCTIONS of Admissions:	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	GIONAL VIL	COFFICE OR 21. 1. 2. 3. 26. TERMINA VOLUNTARY 01-Merger, Closs 02-Dissatisfactio 03-Risk of Involu	SINGLE STAT Statement of Financi Ownership/Control I Both of the Above : TION ACTION: 00 ure n W/ Reimbursemen intary Termination	, Enforcement Specia E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA (1) (1) (1) (1) (1) (1) (1) (1)	L30) X-1513) L30) XARY eet Health/Safety eet Agreement
Gail Anderson Unit (	PART II - TO Y rticipate (L21) 23. LTC AGREEMI BEGINNING (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus	BE COMPLETED 20. COM RIGH 20. C	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	GIONAL VIL	COFFICE OR 21. 1. 2. 3. 26. TERMINA VOLUNTARY 01-Merger, Closs 02-Dissatisfactio 03-Risk of Involu 04-Other Reason	SINGLE STAT Statement of Financi Ownership/Control I Both of the Above : TION ACTION: 00 ure n W/ Reimbursemen intary Termination	, Enforcement Specia E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA (1) (1) (1) (1) (1) (1) (1) (1)	L30) X-1513) L30) XARY eet Health/Safety eet Agreement
Gail Anderson Unit (	PART II - TO Y rticipate (L21) 23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Sus 29 (L28)	BE COMPLETEI 20. COM RIGH 20. C	D BY HCFA RE PLIANCE WITH CI ITS ACT: 4. LTC AGREEMEI ENDING DATE (L25) (L44) (L45) ARRIER NO.	GIONAL VIL NT (L31)	COFFICE OR 21. 1. 2. 3. 26. TERMINA VOLUNTARY 01-Merger, Closs 02-Dissatisfactio 03-Risk of Involu 04-Other Reason	SINGLE STAT Statement of Financi Ownership/Control I Both of the Above : TION ACTION: 00 ure n W/ Reimbursemen intary Termination	, Enforcement Specia E AGENCY al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA (1) (1) (1) (1) (1) (1) (1) (1)	L30) X-1513) L30) XARY eet Health/Safety eet Agreement



#### 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



#### 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 /	MULTIPLE CONSTRUCTION		DAT	TE OF REVIS	IT
IDENTIFICATION NUMBER	A. Building				
245403 <sub>Y1</sub>	B. Wing	Y2	8/2	9/2016	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	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix F0241	Correction	ID Prefix F028	2 Correction	ID Prefix	F0312 Correction
Reg. # 483.15(a)	Completed	Reg. #	0(k)(3)(ii) Complete	d Reg. #	483.25(a)(3) Completed
LSC	08/23/2016	LSC	08/23/2016	LSC	08/23/2016
ID Prefix F0313	Correction	ID Prefix F046	5 Correction	ID Prefix	Correction
483.25(b)	Completed	Reg. #	0(h) Complete	d Reg. #	Completed
LSC	08/23/2016	LSC	08/23/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Complete	d Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Complete	d Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Complete	d Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) GA/mm	<b>DATE</b> 09/12/2016	SIGNATURE OF SURVEYOR	28034	<b>DATE</b> 08/29/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
<b>FOLLOWUP TO SURVEY</b> 7/14/2016	COMPLETED ON	CHECK FC UNCORRE	R ANY UNCORRECTED DEFIC CTED DEFICIENCIES (CMS-25	IENCIES. WAS 67) SENT TO T	A SUMMARY OF HE FACILITY? YES NO

# **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DA	TE OF REVISI	Т
	B. Wing	Y2	9/2	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		DATE	ITEM	DA	TE	ITEM			DATE
Y4		Y5	Y4	Y	(5	Y4			Y5
ID Prefix		Correction	ID Prefix	Corre	ection	ID Prefix			Correction
Reg. #	A 101	Completed	Reg. #	Com	pleted	Reg. #	NFPA 101		Completed
LSC K00	18	09/02/2016	LSC K002	9 08/03	/2016	LSC	K0051		08/03/2016
ID Prefix		Correction	ID Prefix	Corre	ection	ID Prefix			Correction
Reg. #	PA 101	Completed	Reg. #	Com	pleted	Reg. #			Completed
LSC KOOG	62	08/03/2016	LSC K014	1 08/03	/2016	LSC			
ID Prefix		Correction	ID Prefix	Corre	ection	ID Prefix			Correction
Reg. #		Completed	Reg. #	Com	pleted	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix	Corre	ection	ID Prefix			Correction
Reg. #		Completed	Reg. #	Com	pleted	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix	Corre	ection	ID Prefix			Correction
Reg. #		Completed	Reg. #	Com	pleted	Reg. #			Completed
LSC			LSC			LSC			
REVIEWED B STATE AGENO	Y F CY X (I	REVIEWED BY INITIALS) TL/mm	<b>DATE</b> 09/12/2016	SIGNATURE OF SURVI				DATE 09	0/02/2016
REVIEWED B CMS RO		REVIEWED BY INITIALS)	DATE	TITLE				DATE	
FOLLOWUP 1 7/12/2016	TO SURVEY C	COMPLETED ON		DR ANY UNCORRECTED D CTED DEFICIENCIES (CN					5 🗆 NO

# **POST-CERTIFICATION REVISIT REPORT**

IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 02 - 2007 CONNECTING LINK B. Wing	Y. Y.	DATE OF REVIS 9/2/2016	IT Y3
NAME OF FACILITY GOOD SAMARITAN SOCIETY	- BATTLE LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC K0038	08/03/2016	LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
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		
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) TL/mm	<b>DATE</b> 09/12/2016	SIGNATURE OF SURVEYOR 365	36	<b>DATE</b> 09/02	/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
<b>FOLLOWUP TO SURVE</b> 7/12/2016	Y COMPLETED ON		R ANY UNCORRECTED DEFICIEN TED DEFICIENCIES (CMS-2567)	NCIES. WAS A SENT TO TH		5 🔲 NO

DEPARTMENT OF HEALT	TH AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFICAT	FION A	AND TRANSMITTAL	ID: GQ54
	PART I -	TO BE COMPI	LETED BY THE	E STAT	<b>FE SURVEY AGENCY</b>	Facility ID: 00146
1. MEDICARE/MEDICAID PROVIE (L1) 245403	DER NO.		DRESS OF FACILI IARITAN SOCIE		ATTLE LAKE	4. TYPE OF ACTION: <u>2 (</u> L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID	NO.	(L4) 105 GLENH	AVEN DRIVE			1. Initial2. Recertification3. Termination4. CHOW
(L2) <b>150518100</b>		(L5) BATTLE LA	AKE, MN		(L6) <b>56515</b>	5. Validation 6. Complaint 7. On-Site Visit 9. Other
<ol> <li>5. EFFECTIVE DATE CHANGE OF (L9)</li> </ol>	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEGOR	Y 9 esrd	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 07/1	1 <b>4/2016</b> (L34)	02 SNF/NF/Dual	06 PRTF 10	) NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray 11	ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited1 TJC2 AOA3 Other		04 SNF	08 OPT/SP 12	2 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATIO	DN	10.THE FACILITY	' IS CERTIFIED AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
		<sup>^</sup>			3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	55 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	_
13.Total Certified Beds	55 (L17)	X B. Not in Con	pliance with Program	ı	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied Waiv	/ers:	* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
55						
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE Beth Nowling, HFE NEII		Date :	0/10/2017		18. STATE SURVEY AGENCY	
		0	8/18/2016	(L19)	mane meeting	08/28/2016 (L20
PA	ART II - TO BE	COMPLETED I	BY HCFA REGI	IONAL	OFFICE OR SINGLE S	STATE AGENCY
19. DETERMINATION OF ELIGIBI	ILITY		IPLIANCE WITH CI	VIL		ncial Solvency (HCFA-2572)
X 1. Facility is Eligible to	Participate	KIGF	ITS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	ol Interest Disclosure Stmt (HCFA-1513) e :
2. Facility is not Eligible	le (L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEMEN	T	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION	BEGINNINC	6 DATE	ENDING DATE		<u>VOLUNTARY</u> 00	<u>INVOLUNTARY</u>
12/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
	B. Rescind Si	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CAKRIER NO.		30. REMARKS	
	(1.20)	00140		(1.21)		
	(L28)		(	(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL DA	TE		
	(L32)		(	(L33)	DETERMINATION APP	ROVAL



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:

<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:

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.

Good Samaritan Society - Battle Lake July 28, 2016 Page 4

#### 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

Good Samaritan Society - Battle Lake July 28, 2016 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. 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 Good Samaritan Society - Battle Lake July 28, 2016 Page 6

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

Sincerely,

Mark Weath

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			ORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OME	3 NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		245403	B. WING		07/14/2016
NAME OF F	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 000	INITIAL COMMENT	rs	F 000		
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will cion of compliance.			
F 241 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with AND RESPECT OF	F 241		8/23/16
	manner and in an e enhances each res	omote care for residents in a nvironment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on interview facility failed to prov for 1 of 2 residents Findings include: R46's quarterly Min 6/1/16 identified R4 included Alzheimer The MDS identified	NT is not met as evidenced y and document review the yide cares to maintain dignity (R46) reviewed for dignity. imum Data Set (MDS) dated 6 had diagnoses which s disease, abscess and pain. R46 had severe cognitive juired total assistance with all ing (ADLs).		<ol> <li>Resident's (R46) shirt was change 7/12/16.</li> <li>All residents who have history of for 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 Nurs Social Services Director, or designee regarding resident appearances and changing clothing when necessary, keeping residents tidy and clean at all times.</li> <li>The Director of Nursing, Social</li> </ol>	od sing,
LABORATOR	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

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.

08/03/2016

PRINTED: 08/18/2016

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVEI . 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245403	B. WING _		07/	/14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 241	unable to communi dependent on staff assistance with per On 7/12/16, at 2:45 wheelchair, in the lo the television. Two the area, and staff at to walk past R46 se a blue and white str approximately 3 inc area on the front of collar which was co substance. The are appearance. On 7/12/16, at 3:33 wheelchair in her ro was observed to be On 7/12/16, at 3:49 confirmed the soile stated he felt it was the shirt, from food day. On 7/14/16, at 9:55 severe cognitive im on staff for cares. S clothes became dir should be changed dribbled food out of felt there was no re clothes on because at meals and was a On 7/14/16, at 10:0	ted 6/9/16 identified R46 was cate her needs, was totally for dressing and required staff sonal hygiene. 6 p.m. R46 was seated in her bunge of the facility, in front of other residents were seated in and residents were observed eated in the lounge. R46 wore riped shirt and had a ches (in.) long by 3 in. wide ther shirt extending from her overed with a crusted white ea appeared dry, and stiff in 6 p.m. R46 was seated in her born. The same soiled shirt	F 24	<ul> <li>41</li> <li>Services Director, or des provide dignity training to August 9th and 10th, 201 continue to be educated and dignity upon hire and thereafter.</li> <li>4. To monitor performant sustainability, the Directo Social Services Director, perform clothing spot cheresident #46 and random x4 weeks, then randomly audit findings will be report monthly QA meeting for frecommendation.</li> <li>5. Completion Date: August Statement Stateme</li></ul>	all staff on 6. Staff will on resident rights I annually ce and to ensure r of Nursing, or designee, will ecks daily for other residents x3 weeks. All orted to the urther	

If continuation sheet Page 2 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/18/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245403	B. WING _		07/	14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	-	
GOOD SA	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 241	resident's clothes w changed right away mixed with milk and food got on R46's c On 7/14/16, at 10:3 (LPN-A) stated R46 cognitive impairmer on staff for all cares should be changed food is spilled on th feeds residents crue got some food on th wore a clothing pro On 7/14/16, at 12:3 (CM)-A stated R46 impairment and was cares. She stated s be changed in the n routinely if soiled. S have been changed with food. On 7/14/16, at 2:48 confirmed R46 had and was totally dep stated to maintain F staff to ensure R46' R46 to look her bes Review of the facility residents in a mann maintained or enha and respect in full re	sn't that bad. She stated if a vere visibly dirty they should be . She stated R46's food was d fed to her and sometimes lothes. 4 a.m. licensed practical nurse was fed by staff, had severe int and was totally dependent s. She stated resident clothes when they are dirty or when em. She stated she when she shed medications in food she heir shirts. LPN-A stated R46 otector but food got around it. 6 p.m. clinical manager had severe cognitive s totally dependent on staff for he expected resident's clothes morning, at bedtime and he stated R46's shirt should d when her shirt became soiled p.m. director of nursing severe cognitive impairment endent on staff for care. She R46's dignity she expected 's clothes were clean and for st. by policy, Resident Dignity or promoted care for the her and environment that nced each resident's dignity ecognition of their individuality.	F 24			
F 282	residents in a mann maintained or enha and respect in full re	her and environment that need each resident's dignity	F 28	32		8/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         NAME OF PROVIDER OR SUPPLIER       245403       B. WING         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CO         GOOD SAMARITAN SOCIETY - BATTLE LAKE       STREET ADDRESS, CITY, STATE, ZIP CO         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG       ID       PROVIDER'S PLAN OF CORI         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG       ID       PROVIDER'S PLAN OF CORI         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG       ID       PROVIDER'S PLAN OF CORI         (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       TAG       CROSS-REFERENCED TO THE A DEFICIENCY)	CON 07/	TE SURVEY MPLETED (14/2016
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CC         GOOD SAMARITAN SOCIETY - BATTLE LAKE       105 GLENHAVEN DRIVE         BATTLE LAKE, MN 56515       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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A		14/2016
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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE ACTION)		
GOOD SAMARITAN SOCIETY - BATTLE LAKEBATTLE LAKE, MN 56515(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORIPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION STAGTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE ACTION STAG		
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A CROSS-REFERENCED TO THE A		
	SHOULD BE	(X5) COMPLETION DATE
F 282Continued From page 3F 282SS=DPERSONS/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.		
<ul> <li>This REQUIREMENT is not met as evidenced by:</li> <li>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.</li> <li>Findings include:</li> <li>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.</li> <li>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 a preform audits to ensure resupper lip.</li> <li>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.</li> <li>This REQUIREMENT is not met as evidenced by this deficient pravimately 20 long. Gray hairs remained on her chin and upper lip. NA-A stated R46 was waiting for the nurse to assess R46's pain.</li> </ul>	the facility shaving are ntial to be ctice. These ensure care a need. focial ee, will a August 9th y reinforcing ermine inue to be ights and nd to ensure Nursing, designee, will ident #46 and clean shaven yeek x4 eks. All audit ie monthly QA endation. 23, 2016	
On 7/13/16, at 9:50 a.m. R46 was in her 1. Resident (R40) was offere	ed an	

Facility ID: 00146

If continuation sheet Page 4 of 21

	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		0938-03 SURVEY PLETED	
		245403	B. WING _		07/1	4/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC			
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 282	wheelchair in the lo residents in front of to have the long, gr and upper lip. On 7/14/16, at 9:55 severe cognitive im on staff for cares. S shaved on bath day should have been s busy and forgot. S long its been since stated she felt R46 On 7/14/16, at 12:3 (CM-A) stated R46 impairment and wa cares. She stated t admission about th preference. She sta routine care and ex residents as needed be shaved but was for staff to shave he expect the bath aid needed. On 7/14/16, at 2:48 stated R46 had sev was totally depended stated normally the residents but stated must have gotten n	unge area with 2 other the television. R36 continued ray hairs observed on her chin a.m. NA-B stated R46 had pairment and was dependent she stated R46 should be ys. She stated she noticed R46 shaved yesterday but she got he stated she wasn't sure how R46 had been shaved, but	F 28	<ul> <li>appointment on August 2nd 2 her hearing re-tested and assishe refused this. Resident condition assessed quarterly and will be offered audiology appoint is the changes her mind.</li> <li>2. All care plans and docume be reviewed of all residents within the facility to eat their hearing has been assessive audiology appointments have offered. Care plans reflect to which gives direction to staff hearing assistive devices.</li> <li>3. The Director of Nursing, S Services Director, or designed provide training to all staff on and 10th, 2016, specifically ruse of the Kardex to determineed. Staff will continue to be on PCC, resident rights and ohire.</li> <li>4. To monitor performance and sustainability, the Director of Social Service Director, or designed perform audits 5x/week x4 wir randomly x3 weeks. All audit be reported to the monthly Q further recommendation.</li> <li>5. Completion Date: August 2</li> </ul>	sessed but ontinues to be be continue to ments in case entation will with hearing nsure that seed and been the Kardex for use of ocial ee, will August 9th einforcing the ne resident e educated dignity upon nd to ensure Nursing, esignee, will eeks, then findings will A meeting for		

If continuation sheet Page 5 of 21

		AND HUMAN SERVICES				FORM	08/18/2016 APPROVED
STATEMENT	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		245403	B. WING			07/14/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE			05 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	to monitor effective to ensure devices fi On 7/12/16, at 1:14 chair in the dining re- hearing amplifier in (NA)-F spoke to R4 asked R40 if she w R40 stood from the wheeled walker and back to her room. V towards R40's room raised voice toward what she planned of R40 replied she did to R40 that the facil activity commented can you?," that's too to hymn music." R4 walked to her room R40's hearing ampli- charging station on On 7/13/16, at 7:05 rocker chair in her room chair. On 7/13/16, at 8:17 room with her 4 wh- walking next to her assisted R40 to a s the dining room. NA explained to her wh- placed. R40 was no instructions. NA-F to	ge 5 hard of hearing, directed staff ness of hearing amplifier and unctioning and availability. p.m. R40 was seated in a oom, R40 did not have a place. Nursing assistant 0 with a raised voice and anted to go back to her room. chair and took a hold of her 4 d NA-F walked next to R40 Vhile walking in the hallway n, NA-F spoke to R40 with a s her left ear and asked R40 on doing for the rest of the day. not know. NA-F then stated lity had hymn singing for an to R40, "but you can't hear it o bad you used to love going 0 did not respond to NA-F and and sat in a rocker chair. ifier was observed to be in a the side table in her room. a.m. R40 was seated in her room. R40's hearing amplifier in the charging station on the om, on the right of her rocker	F 2	282			

Facility ID: 00146

If continuation sheet Page 6 of 21

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	TIPLE C	ONSTRUCTION	OMB NC	TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				· · /	MPLETED
		245403	B. WING _	B. WING			/14/2016
NAME OF F	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 ( BAT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 282	Continued From pa	age 6	F 28	82			
	explained to her wh	nere on her plate her foods					
		anded R40 a spoon. R40 was					
		act to NA-F's instructions and ray for her foods and felt for					
		R40 did not converse or					
		of the two tablemate's or staff					
		akfast meal. R40 was not					
	the observation.	g amplifier at any time during					
	On 7/14/16. at 1:04	p.m. R40 was seated in a					
	chair in the dining r	oom eating the noon meal.					
		ing amplifier and was If seated at another table.					
	On 7/12/16, at 2:37	p.m. R40 was seated in her					
		hair. On the right of the rocker					
		ble which held a charging ng amplifier with headphones.					
		to R40 and speaking directly					
		R40 stated her days consisted					
		everyday, eating meals and					
		R40 stated she used to attend the facility but could not					
		r poor hearing. R40 stated her					
	hearing had been g	radually declining the past few					
		d she used to wear a hearing					
		a headphone device which did nymore. R40 stated she felt					
		ware she could not hear them,					
		R40 stated she felt her days					
		ne often slept through most of					
	2	ed she felt it was hard to carry with others at times because of					
		nd felt others may get					
	impatient with her.	R40 further stated facility staff					
		Ik to her once in a while for a					
	minutes, never minutes and did ge	more than a couple of	1				

Facility ID: 00146

If continuation sheet Page 7 of 21

		AND HUMAN SERVICES			FORM	08/18/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245403	B. WING		07/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	Continued From par she used to love go facility, but could no was not able to atter poor hearing. On 7/13/16, at 11:4 confirmed R40 had longer attended mu hearing. AD stated books or the radio i since the beginning received 1:1 visits f a week and would g AD stated she was wearing her hearing On 7/13/16, registe R40 was very hard assistive devices to R40 should wear he waking hours and v on her ears indeper unaware R40 was r amplifier though ha when R40 stopped RN-A stated hearing quarterly with the M changes. RN-A con assessed with last I On 7/13/16, at 12:2 (LPN)-B stated R40	age 7 bing to music events at the b longer hear the music and end group activities due to her 9 a.m. activity director (AD) hearing impairment and no usical activities due to her poor R40 used to listen to talking in her room, but had stopped of the year. AD stated R40 rom an activity aid three times generally run 10-15 minutes. not aware R40 was no longer	F 28	DEFICIENCY)		
	wearing the amplifie stated she was not the amplifier and co RN-A of R40 not ut	er the previous week. LPN-B sure why R40 stopped using onfirmed she did not notify				

If continuation sheet Page 8 of 21

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/18/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245403	B. WING		07/	14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282 F 312 SS=D	overall status had b and R40 needed m such as dressing at was very hard of he amplifier to use whe R40 sometimes use was able to use it a R40 no longer went hearing loss. NA-F last time she saw R confirmed she had amplifier. On 7/14/16, at 10:1 (SS) stated she had changed again bas room. SS stated sh using the hearing a music groups. SS s benefit form freque increase in isolation On 7/14/16, at 1:18 (DON) stated she w when R40 stopped and would expect F re-assessed if any o reported by R40. Th R40's care plan to b with hearing device 483.25(a)(3) ADL C DEPENDENT RES A resident who is un daily living receives	een changing since last winter ore assistance with ADL's and grooming. NA-F stated R40 earing and had a hearing en she wanted to. NA-F stated ed the amplifier for lunch and s she wanted. NA-F stated to activities due to her stated she could not recall the 40 using the amplifier and not offered R40 the use of the 8 a.m. social service director d felt R40's hearing had ed on R40 remaining in her e was not aware R40 was not mplifier and was not attending tated she felt R40 would nt 1:1 visits to prevent h. p.m. the director of nursing yould expect her staff to notice wearing the hearing amplifiers R40's hearing to be changes were observed or ne DON stated she expected be followed and staff to assist s as needed or directed. ARE PROVIDED FOR	F 282			8/23/16

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		AND HUMAN SERVICES				FORM	08/18/2016 APPROVED 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245403	B. WING _			07/	14/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 5 GLENHAVEN DRIVE	-	
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 9	F 3 <sup>-</sup>	12			
	by: Based on interview facility failed to prov 1 residents (R46) re living (ADLs). Findings include: R46's quarterly Min 6/1/16 identified R4 included Alzheimer' The MDS identified impairment and rec activities of daily liv R46's care plan dat self care deficit rela prosthesis removal required staff assis and preferred staff On 7/11/16, at 2:26 wheelchair in the lo with visitors and oth had approximately her chin and 1 very upper lip. On 7/12/16, at 3:33 wheelchair in her ro hairs remained on h stated R46 was wa R46's pain. On 7/13/16, at 9:50	NT is not met as evidenced y and document review the yide grooming services for 1 of eviewed for activities of daily imum Data Set (MDS) dated 6 had diagnoses which s disease, abscess and pain. R46 had severe cognitive juired total assistance with all ing (ADLs). red 6/9/16 identified R46 had a ted to dementia and left hip . The care plan identified R46 tance with personal hygiene to shave her facial hair. S p.m. R46 was in her unge area in front of the TV her residents in the area. R46 20 long, gray, course hairs on long gray, curled hair on her p.m. R46 was in her p.m. R46 was in her oom with NA-A. The long, gray her chin and upper lip. NA-A atting for the nurse to assess			<ol> <li>Resident's (R46) facial hair was shaved 7/14/16.</li> <li>All female residents within the fa who require assistance with shavin identified as having the potential to affected by this same deficient prace These residents will be reviewed to ensure care plan is updated to reflect need.</li> <li>The Director of Nursing, Social Services Director, or designee, will provide training to all staff on Augus and 10th of 2016, specifically reinfor the use of the Kardex to determine resident need. Staff will continue to educated on PCC, resident rights a dignity upon hire.</li> <li>To monitor performance and to e sustainability, the Director of Nursin Social Services Director, or designe perform audits to ensure resident # other random residents are clean s as appropriate, auditing 5x/week x4 weeks, then randomly x3 weeks. A findings will be reported to the mon meeting for further recommendatio 5. Completion Date: August 23, 20</li> </ol>	cility g are be ctice. ect this ect this st 9th orcing be und ensure ng, ee, will 446 and haven 4 All audit thly QA n.	

CENTE		AND HUMAN SERVICES & MEDICAID SERVICES	-			/I APPROVE[ ). 0938-039 <sup>-</sup>
-	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245403	B. WING _		07	//14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE	
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 312	residents in front of to have the long, gr and upper lip. On 7/14/16, at 9:55 severe cognitive im on staff for cares. S shaved on bath day should have been s busy and forgot. SH long its been since stated she felt R46 On 7/14/16, at 10:0 dependent on staff R46's cognition was facial hair was long shaved. She stated was shaved last but On 7/14/16, at 10:3 (LPN-A) stated R46 impairment and was all cares. She stated shaved on bath day noticed. She stated shaved her once a	the television. R36 continued ay hairs observed on her chin a.m. NA-B stated R46 had pairment and was dependent the stated R46 should be rs. She stated she noticed R46 haved yesterday but she got ne stated she wasn't sure how R46 had been shaved, but	F 3			
	Couldn't be sure. On 7/14/16, at 12:3 (CM-A) stated R46 impairment and was cares. She stated th admission about the	ems with facial hair, but 6 p.m. clinical manager had severe cognitive s totally dependent on staff for he facility asked residents on eir individual shaving tted shaving was a part of				

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTI	PLE CONSTRUCTION (X:	) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		245403	B. WING _		07/14/2016
	PROVIDER OR SUPPLIER	- ΒΔΤΤΙ ΕΙ ΔΚΕ		STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE	
				BATTLE LAKE, MN 56515	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E
F 312	Continued From pa	ge 11	F 31	2	
	to shave her. She s	t was not care planned for staff tated she would expect the to shave R46 as needed.			
	stated R46 had sev was totally dependent stated normally the residents but stated must have gotten m	p.m. director of nursing ere cognitive impairment and ent on staff for care. DON bath aide took care of shaving d she was on vacation and she hissed. She stated staff knew ed R46's facial hair and R46 her best.			
F 313 SS=D	resident who is una receive the necessa maintain grooming	y policy, ADLs identified any ble to carry out ADLs will ary care and services to and personal hygiene. ENT/DEVICES TO MAINTAIN	F 31	3	8/23/16
	and assistive device hearing abilities, the assist the resident i by arranging for tra office of a practition treatment of vision office of a profession	dents receive proper treatment es to maintain vision and e facility must, if necessary, n making appointments, and nsportation to and from the her specializing in the or hearing impairment or the onal specializing in the or hearing assistive devices.			
	by: Based on observat review the facility fa was provided which hearing abilities and	NT is not met as evidenced tion, interview and document liled to ensure proper care included reassessment of d devices for 1 of 1 residents inced a decrease in hearing		1. Resident (R40) was offered an appointment on August 2nd 2016 to h her hearing re-tested and assessed b she refused this. Resident continues t assessed quarterly and will be continues	ut o be

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If continuation sheet Page 12 of 21

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED	
		DENTRICATION NOMBER.	A. BUILDING	G			
		245403	B. WING			4/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLETIC DATE	
F 313	Continued From pa	age 12	F 31:	3			
	abilities.	-		be offered audiology app	ointments in case		
	Findings include:			<ul> <li>she changes her mind.</li> <li>2. All care plans and doc</li> <li>be reviewed of all resider</li> </ul>			
	(MDS) dated 5/4/10 cognitively intact and included anxiety, d The MDS identified hearing, used a he extensive assistant daily living (ADL's.) Review of R40's co Assessment (CAA)	Jarterly Minimum Data Set 6, identified R40 was nd had diagnoses which epression and legal blindness. d R40 had moderate difficulty aring device and required ce from staff for activities of ommunication Care Area ) dated 11/20/15, identified R40 aring loss and had complaints		deficits within the facility their hearing has been as audiology appointments offered. Care plans reflec which gives direction to s hearing assistive devices 3. The Director of Nursin Services Director, or des provide training to all sta and 10th, 2016, specifica use of the kardex to dete need. Staff will continue	to ensure that ssessed and have been ct to the kardex staff for use of s. g, Social ignee, will ff on August 9th ally reinforcing the ermine resident		
	of increased difficu amplifier. The CAA assistance with pla the hearing amplifie R40 had reported s used to and had im the assessment wh Review of R40's ca identified R40 was to monitor effective	Ity hearing and used a hearing identified R40 required staff icement and maintenance of er. The CAA further identified she did not hear as well as she inpacted cerum at the time of nich required treatment. are plan revised 6/4/14, hard of hearing, directed staff eness of hearing amplifier and		<ul> <li>on PCC, resident rights a hire.</li> <li>4. To monitor performant sustainability, the Director Social Services Director, perform audits 5x/weeks and omly x3 weeks. All a be reported to the month further recommendation.</li> <li>5. Completion Date: Aug</li> </ul>	and dignity upon ce and to ensure or of Nursing, or designee, will x4 weeks, then audit findings will ily QA meeting for		
	Review of R40's ca 5/17/16, revealed F required to the use Review of R40's ph 5/22/16, noted a re	functioning and availability. are conference note dated R40 was hard of hearing and of a hearing amplifier. hysician progress note dated eview of systems by R40's ce which revealed R40 had					

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		AND HUMAN SERVICES				FORM	08/18/2016 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245403	B. WING			07/ <sup>.</sup>	14/2016
NAME OF PRO	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAN	MARITAN SOCIETY	- BATTLE LAKE			05 GLENHAVEN DRIVE ATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
C chh(la F wbttrawF ttacttwF c C rowsc C rowatte pirse wn	chair in the dining ro- nearing amplifier in NA)-F spoke to R4 asked R40 if she war R40 stood from the wheeled walker and back to her room. V owards R40's room aised voice toward what she planned o R40 replied she did o R40 that the facil activity commented can you?," that's too o hymn music." R4 walked to her room R40's hearing ampli- charging station on Dn 7/13/16, at 7:05 tocker chair in her room chair. Dn 7/13/16, at 8:17 toom with her 4 who walking next to her assisted R40 to a si- he dining room. NA- explained to her who placed. R40 was no nstructions. NA-F back spoke into R40's left explained to her who were located and have not observed to real	ge 13 p.m. R40 was seated in a oom, R40 did not have a place. Nursing assistant 0 with a raised voice and anted to go back to her room. chair and took a hold of her 4 d NA-F walked next to R40 Vhile walking in the hallway n, NA-F spoke to R40 with a ls her left ear and asked R40 on doing for the rest of the day. I not know. NA-F then stated lity had hymn singing for an to R40, "but you can't hear it o bad you used to love going 0 did not respond to NA-F and and sat in a rocker chair. lifier was observed to be in a the side table in her room. a.m. R40 was seated in her room. R40's hearing amplifier e in the charging station on the om, on the right of her rocker a.m. R40 walked to the dining eeled walker with NA-B on R40's right side. NA-G eated position on a chair in A-G stood behind R40 and here on the tray her fluids were ot observed to react to NA-G's prought R40's plate to her and ft ear with a raised voice and here on her plate her foods anded R40 a spoon. R40 was not to NA-F's instructions and ray for her foods and felt for	F 3	313			

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		AND HUMAN SERVICES				FORM	08/18/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
		245403	B. WING			07/	14/2016
NAME OF	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE					
					BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 313	interact with either throughout the brea wearing her hearing the observation. On 7/14/16, at 1:04 chair in the dining r R40 wore her hearing conversing with sta On 7/12/16, at 2:37 room, in a rocker c chair was a side tal station and a hearing While seated close into R40's left ear, of the same thing east sitting in her room. the music events a anymore due to he hearing had been g months. R40 stated aid and then used a not seem to help at the staff were not a but was used to it. ran together and sh her days. R40 stated on a conversation wher poor hearing at impatient with her. would come and ta few minutes, never minutes and did ge she used to love go facility, but could no	age 14 R40 did not converse or of the two tablemate's or staff akfast meal. R40 was not g amplifier at any time during 4 p.m. R40 was seated in a room eating the noon meal. ing amplifier and was off seated at another table. 7 p.m. R40 was seated in her hair. On the right of the rocker ble which held a charging ng amplifier with headphones. to R40 and speaking directly R40 stated her days consisted everyday, eating meals and R40 stated she used to attend t the facility but could not r poor hearing. R40 stated her gradually declining the past few d she used to wear a hearing a headphone device which did nymore. R40 stated she felt tware she could not hear them, R40 stated she felt her days ne often slept through most of ed she felt it was hard to carry with others at times because of nd felt others may get R40 further stated facility staff lk to her once in a while for a more than a couple of et lonely at times. R40 stated bing to music events at the o longer hear the music and end group activities due to her		313			

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		AND HUMAN SERVICES			FORM	08/18/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245403	B. WING		<b>07</b> /	14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 313	Continued From pa	ige 15	F 313	3		
	confirmed R40 had longer attended mu hearing. AD stated books or the radio i since the beginning received 1:1 visits f a week and would g AD stated she was wearing her hearing On 7/13/16, registe R40 was very hard assistive devices to R40 should wear he waking hours and w on her ears indeper unaware R40 was r amplifier though ha when R40 stopped RN-A stated hearing quarterly with the M changes. RN-A con assessed with last I RN-A confirmed R4 monitor the use of t On 7/13/16, at 12:2 (LPN)-B stated R40 wearing her hearing wearing the amplifie stated she was not the amplifier and co RN-A of R40 not uti On 7/13/16, at 9:43	ared nurse (RN)-A confirmed of hearing and required o aid in hearing. RN-A stated er hearing amplifier during was able to place the amplifier ndently. RN-A stated she was no longer wearing the hearing ad expected staff to notify her wearing the hearing amplifier. g assessment were completed IDS and as needed with firmed R40's hearing was last MDS, back in May of 2016. HO's care plan directed staff to the hearing amplifier. 3 p.m. licensed practical nurse D had not been routinely g amplifier and had stopped er the previous week. LPN-B sure why R40 stopped using onfirmed she did not notify ilizing the amplifier.				
		been changing since last winter ore assistance with ADL's				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/18/2016 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		245403	B. WING		07/	14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 313	was very hard of he amplifier to use whe R40 sometimes use was able to use it a R40 no longer went hearing loss. NA-F last time she saw R confirmed she had amplifier. On 7/14/16, at 10:1 (SS) stated she had changed again bask room. SS stated sh using the hearing a music groups. SS s benefit form freque increase in isolation On 7/14/16, at 1:18 (DON) stated she w when R40 stopped and would expect F re-assessed if any o reported by R40. Th R40's care plan to b with hearing device Review of a facility Communicating Info	had grooming. NA-F stated R40 earing and had a hearing en she wanted to. NA-F stated ed the amplifier for lunch and s she wanted. NA-F stated t to activities due to her stated she could not recall the 40 using the amplifier and not offered R40 the use of the 8 a.m. social service director d felt R40's hearing had ed on R40 remaining in her e was not aware R40 was not mplifier and was not attending stated she felt R40 would nt 1:1 visits to prevent h. p.m. the director of nursing yould expect her staff to notice wearing the hearing amplifiers	F 313			
F 465 SS=D	appropriate interver 483.70(h)		F 465			8/23/16

		AND HUMAN SERVICES				FORM	08/18/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245403	B. WING	i		<b>07</b> /-	14/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE			05 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	Continued From pa	ge 17	F4	465			
		ovide a safe, functional, ortable environment for the public.					
	by: Based on observat review, the facility fi equipment was ma operation for 1 of 1 front wheeled walke Findings include: R36's Significant C dated 4/27/16, iden which included arth The MDS identified and required super walking. R36's care plan dat limited physical mo macular degenerati wheeled walker with assistance for amb On 7/11/16, at 6:12 the dining room afte the hallway towards and nursing assista front legs of R36's weels balls. R36's wheels	hange Minimum Data Set, tified R36 had diagnoses ritis, anxiety and depression. R36 was cognitively intact vision and assistance with red 5/1/16 identified R36 had bility due to osteoarthritis and ion and required a front h occasional stand-by			<ol> <li>Resident's (R36) walker was cle front wheels were greased and new balls were placed 7/15/16.</li> <li>All residents within the facility wh walkers are identified as having the potential to be affected by the same deficient practice. All walkers will be inspected monthly to ensure they an clean and in good repair.</li> <li>The Director of Maintenance, Environmental Services Director, or designee, will provide education relations this issue to all maintenance staff of August 9th and 10th, 2016. Mainter staff will continue to be educated or process upon hire. The Director of Nursing, Social Services Director, or designee, will provide education to a nursing staff on August 9th and 10th 2016, related to this issue, ensuring day cleanliness of resident's walker Nursing staff will continue to be edu on this process upon hire.</li> <li>To monitor performance and to e sustainability, the Director of Maintenance, the Environmental Se Director, or designee, will perform a weekly x4, then monthly x2. All aud findings will be reported to the mont meeting for further recommendation</li> </ol>	v tennis o use o use re ated to n nance n this or all n, day to	

Facility ID: 00146

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 08/18/2016 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245403	B. WING		07/	/14/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		05 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 465	On 7/13/16, at 8:30 ambulate out the di R36 could only mak walker while the fro appeared to be stic jumping or not rollir walker made loud r noises as he left the On 7/14/16, at 12:1 was wrong with the stated the walker m sometimes. He sta made noise. R36 st work, and it hadn't stated a staff perso the past, but the wa correctly. On 7/14/16, at 12:1 room to his seat in R36's walker made wheels didn't turn. entire way. NA-E pa stated "did that wak NA-E continued do continued to drag w On 7/14/16, at 12:2 walker was "pretty s aware of this in the could hear the nois R36 was extremely R36 told her he cou stated she didn't kn repair R36's walker	<ul> <li>a.m. R36 was observed to ning room, with his walker.</li> <li>ke hesitant steps behind the nt wheels of R36's walker king on the floor, at times ng at all. The wheels of the ubbing noises and vibrating e dining room.</li> <li>3 p.m. R36 stated something back end of his walker. He hade it hard for him to walk ted it vibrated and rattled and tated he told staff it didn't worked for quite awhile. He n had looked at his walker in alker was still wasn't working</li> <li>9 p.m. R36 walked from his the dining room for lunch. loud noises and his walker R36's walker dragged the assed by R36 on his way and te you up?" and laughed. wn the hallway and R36 valker to his room.</li> <li>8 p.m. NA-C stated R36's squeaky". She stated she was past and asked him if he e from the walker. She stated hard of hearing and stated uld even hear the noise. She ow if anyone had attempted to</li> </ul>	F 465			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	08/18/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245403	B. WING		07/ <sup>.</sup>	14/2016
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		05 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 465	sprayed the wheels weeks ago and stat She stated she was still not fixed. She si operations and mai responsible for repa resident walkers. On 7/14/16, at 12:5 not aware R36's wa and indicated he ha walker. On 7/14/16, at 1:13 walker wasn't good and stated he felt th didn't roll like they si balls needed to be would get him new R36 utilized was a fi repaired and replace On 7/14/16, at 2:48 yesterday she hear hallway before she was really noisy. Sh tennis balls were of DBOM yesterday an fixed it. She stated and repair walkers should be on alert fi repair and staff sho to maintenance in w maintenance should fixed. On 7/14/16, at 3:30 manufacturer's inst	age 19 s with WD40(lubricant) a few ted she thought it would be ok. sn't aware R36's walker was stated the director of building intenance (DBOM) was air and maintenance of 66 p.m. DBOM stated he was alker had not been working, ad not seen R36 use his 8 p.m. DBOM stated R36's 1. He confirmed the loud noise he tennis balls were worn and should. He stated the tennis replaced on R36's walker and ones. He confirmed the walker facility owned walker and they ced facility owned walkers. 8 p.m. DON stated stated rd R36 coming down the seen him because his walker he stated she felt maybe the ff. She stated she talked to nd stated she just assumed he she expected staff to identify as needed. She stated all staff for equipment which needed build communicate work orders writing or verbally and then d let everyone know after its 0 p.m. DBOM provided the tructions for mobility aids on wheelchair inspection. DBOM	F 465			

Facility ID: 00146

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		AND HUMAN SERVICES				FORM	08/18/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245403	B. WING	i		07/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	·	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE			105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 465	resident care equip	age 20 hey used for their maintaining ment policy and confirmed he e walker in the recent past.	F	465			

Facility ID: 00146

If continuation sheet Page 21 of 21

		AND HUMAN SERVICES		Ŧ	-5403026	FORM	08/08/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245403	B. WING	<u> </u>		07/	12/2016
	PROVIDER OR SUPPLIER	- BATTLE LAKE		1	STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM VERIFICATION OF UPON RECEIPT C	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST 1S-2567 WILL BE USED AS F COMPLIANCE. OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE					
	<b>REGULATIONS H</b>	VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Marshal Division. A Samaritan Society was found not in su requirements for pa Medicare/Medicaid 483.70(a), Life Saf edition of National	Survey was conducted by the nent of Public Safety State Fire At the time of this survey Good Battle Lake, 01 Main Building ubstantial compliance with the articipation in I at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association I01, Life Safety Code (LSC),					

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

Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF

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

TITLE

POC

(X6) DATE 08/04/2016

**Electronically Signed** 

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.

		E & MEDICAID SERVICES				1	0938-039 E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		DNSTRUCTION MAIN BUILDING 01		IPLETED
		245403	B, WING			07/	12/2016
IAME OF I	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
SOOD S	AMARITAN SOCIETY	- BATTLE LAKE			GLENHAVEN DRIVE I'LE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETIO DATE
K 000	Continued From pa	age 1	ĸ	000			
	Or by e-mail to: Marian.Whitney@s and						
	Angela.Kappenma	n@state.mn.us					
		ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:					
	1. A description of to correct the defic	what has been, or will be, done iency.	6				
	2. The actual, or p	roposed, completion date.					
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency					
	The facility was su	rveyed as two buildings.					
	1-story building, wi building was built in be Type II(000) con the south of the we north wing (Occup	an Society Battle Lake is a thout a basement. The original n 1973 and was determined to nstruction. In 1994 additions to est wing and to the north of the ational and Physical Therapy -					
	were determined to In 2004 a small ve wing which include Type II (000) const	tructed. The 1994 additions o be Type V(111) construction. stibule was added to the west ed a walk in freezer, which is truction. In 2007 a connecting sisted living apartments, was		-			
	be Type V (111). In was constructed to which is 1-story, no	a wing and was determined to a 2010 an entrance addition b the north of the dining room b basement and Type II (000) 11 a 16 bed addition was					

Event ID: GQ5421

Facility ID: 00146

If continuation sheet Page 2 of 8

				FORM	: 08/08/2016 APPROVED
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	E SURVEY IPLETED
	245403	B. WING		07/	/12/2016
				P CODE	
MARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
addition was added wing and was deter construction. The smoke compartment barriers. The entire building system installed in Standard for the Ins (1999 edition). A fire smoke detection ar areas which was up with NFPA 72 "The (1999 edition), that department notificat detection is provide Minnesota State Fire The facility has a cat census of 53 reside inspection. The requirement at NOT MET as evide NFPA 101 LIFE SA Doors protecting co required enclosures hazardous areas sl as those constructed core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist th no impediment to t	to the east of the south east mined to be Type II (111) building is divided into 3 ints by 30 minute rated fire is sprinkler protected with a accordance with NFPA 13 stallation of Sprinkler Systems e alarm system with corridor nd smoke detection in common odated in 2010 in accordance National Fire Alarm Code" is monitored for automatic fire ition. Additional automatic fire ed in accordance with the re Code (2007 edition). apacity of 55 beds with a ents at the time of the to the substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ince between bottom of door is not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is he closing of the doors. Hold		000		9/2/16
	S FOR MEDICARE DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER MARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa addition was added wing and was deter construction. The smoke compartment barriers. The entire building system installed in Standard for the Ins (1999 edition). A fir smoke detection ar areas which was up with NFPA 72 "The (1999 edition), that department notificat detection is provide Minnesota State Fi The facility has a ci- census of 53 reside inspection. The requirement at NOT MET as evide NFPA 101 LIFE SA Doors protecting co- required enclosure hazardous areas s as those constructor core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist th no impediment to to open devices that a pushed or pulled a	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         245403         ROVIDER OR SUPPLIER         MARITAN SOCIETY - BATTLE LAKE         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.       (X2) MUL A. BUILD         245403       B. WING         ROVIDER OR SUPPLIER       245403       B. WING         MARITAN SOCIETY - BATTLE LAKE       ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIT TAG         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.       K C addition of 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 department notification. Additional automatic fire department notification. Additional automatic fire department notification. Additional automatic fire department at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD       K M         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 p	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDER/SUPPLER/CLM IDENTIFICATION NUMBER       (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01         ROVIDER OR SUPPLIER       245403       B. WING         MARITAN SOCIETY - BATTLE LAKE       STREET ADDRESS, CITY, STATE, ZI 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WUST BE PRECEDED BY FULL REGULATORY OR LSC. IDENTIFYING INFORMATION)       PREFX TAG       PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCY         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.       K 000         Continued From page 2 addition, Afine alarn system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarn Code" (1999 edition), Afine alarn system with corridor smoke detection and smoke detection is provided in accordance with NFPA 72 "The National Fire Alarn Code" (1999 edition), Afine alarn system with corridor smoke detection and smoke detection is provided in accordance with NFPA 72 "The National Fire Alarn Code" (1999 edition), Afine alarn System fire detection is provided in accordance with the Minnesota State Fire Code (2007 edition).       K 018         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 134 inch solic-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance betwee	MENT OF HEALTH AND HUMAN SERVICES COMBINE S FOR MEDICARE & MEDICAID SERVICES OMBINE S FOR MEDICARE & MEDICAID SERVICES OMBINE CORRECTION MUSER (245403 B) VINC A BUILDING 01 A BUILDING 01 245403 B) VINC A BUILDING 01 A BUILDING 01 A BUILDING 01 - MAIN BUILDING 01 A BUILDI

Facility ID: 00146

If continuation sheet Page 3 of 8

		E & MEDICAID SERVICES				0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
	X	245403	B. WING		<b>07</b> /'	2/2016
IAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		05 GLENHAVEN DRIVE ATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 018	permitted. Door fra made of steel or of with 8.2.3.2.1. Roll CMS regulations in 19.3.6.3 This STANDARD Based on observa facility failed to ma 2 sets of corridor of LSC (00) section 1 practice could affer residents and an u and visitors, if smo	age 3 a doors meeting 19.3.6.3.6 are ames shall be labeled and ther materials in compliance er latches are prohibited by a all health care facilities. is not met as evidenced by: ation and staff interview, the intain the smoke resistance of loors according to NFPA 101 9.3.6.3.1. This deficient ct the safety of 17 of the 53 indetermined amount of staff oke from a fire were allowed to ass corridors making it	K 018	Doors to the identified clean linen will be replaced with a positive latc hardware that will not require empl assistance to close. Completion Date:September2,2010 Facility Maintenance Director will h monitoring of this system on the Preventative Maintenance Audit for monthly review.	hing oyee S ave	
K 029 SS=E	on 07/12/2016 obs revealed the corric rooms located acre and 105 did not po This deficient cond Maintnenance Eng NFPA 101 LIFE S/ One hour fire rated fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro the approved auto option is used, the other spaces by sr doors. Doors are field-applied protee	dition was verified by the gineer. AFETY CODE STANDARD d construction (with o hour r an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When matic fire extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or ctive plates that do not exceed a bottom of the door are	K 029	5		8/3/16

Event ID: GQ5421

Facility ID: 00146

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	1 ' '	E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING	01 - MAIN BUILDING 01	07/12/2016	
		245403	B. WING			
	PROVIDER OR SUPPLIER	- BATTLE LAKE	10	TREET ADDRESS, CITY, STATE, ZIP CODE 05 GLENHAVEN DRIVE ATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 029 K 051 SS=D	This STANDARD is Based on observar facility failed to mais partitions and doors in accordance with 2000 NFPA 101, Se practice could affect an undetermined a Findings include: On the facility tour on 07/12/2016 observe revealed the oxyger resident room 109 This deficient cond Maintenance Engir NFPA 101 LIFE SA A fire alarm system components appro accordance with N and NFPA 72, National provide effective we building. Fire alarm transmission paths Initiation of the fire means and by any alarm, detection de Manual alarm boxe egress near each re boxes in patient sle required at exits if located at all nurse notification is provi signals. In critical of sufficient. The fire	s not met as evidenced by: tion and staff interview, the ntain smoke-resisting s in 1 of the hazardous rooms the following requirements of ection 19.3.2.1. The deficient of 17 of the 53 residents and mount of staff and visitors. between 8:30 am to 1:30 pm ervations and staff interview n storage room across from did not have a door closer. ition was verified by the neer. FETY CODE STANDARD is installed with systems and ved for the purpose in FPA 70, National Electric Code onal Fire Alarm Code to arning of fire in any part of the n system wiring or other are monitored for integrity. alarm system is by manual required sprinkler system. es are provided in the path of equired exit. Manual alarm exice, or detection system. es are provided in the path of equired exit. Manual alarm exice, or cupant ded by audible and visual are areas, visual alarms are alarm system transmits the y to notify emergency forces in	K 029	Director of Maintenance will insta closing device on this door. The of will be monitored routinely through facility. Preventative Maintenance process will give a report at the fa- quarterly QAPI meetings. Comple Date: August 3, 2016	levice 1 the e cility	8/3/16

		AND HUMAN SERVICES		0	the second second	APPROVE 0938-039
ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245403	B. WING		07/1	2/2016
IAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
SOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 051	<ul> <li>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.</li> <li>Findings include:</li> </ul>		K 051	051 The identified smoke detectors have been moved to assure compliance with the NFPA 101 Life Safety Code. An electrical contractor has been retained make the changes. Completion Date: August 3, 2016		
K 062 SS=D	On the facility tour on 07/12/2016 obs revealed the smok within 36 inches of This deficient cond Maintenance Engir NFPA 101 LIFE SA Required automatic continuously maint condition and are in periodically. 19.7 9.7.5 This STANDARD Base on observator the facility has faile automatic sprinkler NFPA 101 Life Saf and 4.6.12, NFPA Systems (99), and Inspection, Testing Based Fire Protect	between 8:30 am to 1:30 pm ervations and staff interview e detector in the kitchen was an HVAC supply diffuser. lition was verified by the neer. NFETY CODE STANDARD c sprinkler systems are ained in reliable operating nspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: ons and interview with staff, ed to properly maintain the r system in accordance with ety Code (00), Section 19.7.6, 13 Installation of Sprinkler NFPA 25 Standard for the and Maintenance of Water ion Systems, (98). This loes not ensure that the fire	K 062	The facility Maintenance Director v install a escutcheon at the identifier sprinkler head. Completion Date: August 3, 2016		8/3/16

Event ID: GQ5421

Facility ID: 00146

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA1	. 0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	IG 01 - MAIN BUILDING 01	COM	MPLETED
		245403	B. WING		07	/12/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 062	the event of a fire a	age 6 ould function properly and in and could negatively affect, an unt of staff and visitors.	K 06	32		
	on 07/12/2016 obs revealed an escuto head in a storage o lounge.	between 8:30 am to 1:30 pm ervations and staff interview heon missing from a sprinkler loset located next to the staff				
K 141 SS=E	Maintenance Engir NFPA 101 LIFE SA Medical gas storag precautionary sign, ft, that is conspicue gate of the storage	ition was verified by the neer. FETY CODE STANDARD e areas shall have a readable from a distance of 5 busly displayed on each door or room or enclosure. The sign llowing wording as a minimum:	K 14	41		8/3/16
	WITHIN, NO SMO 8-3.1.11.3 (NFPA 9 This STANDARD Based on observa facility failed to con regulation when ox signage was not in (00) Life Safety Co deficient practice co	CING GAS(ES) STORED KING. 18.3.2.4, 19.3.2.4, (9) is not met as evidenced by: tion and staff interview the nply with the smoking cygen is in use. The proper place as listed in NFPA 101 de section 19.7.4. This ould negatively affect 8 of the n undetermined amount of		The facility Maintenance Direct install a escutcheon at the ident sprinkler head. Completion Date: August 3, 201	ified	
	On the facility tour on 07/12/2016 obs	between 8:30 am to 1:30 pm ervations and staff interview king oxygen in use sign				

		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 08/08/2010 APPROVEI . 0938-039
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01				TE SURVEY MPLETED	
	245403					07	/12/2016
	PROVIDER OR SUPPLIER	- BATTLE LAKE		105 GLENHAV	ISS, CITY, STATE, ZIP C EN DRIVE (E, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH	OVIDER'S PLAN OF CO I CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
K 141	Continued From pa missing from an ex room.	age 7 kit door outside of the therapy	K	141			
	This deficient pract Maintenance Engir	tice was verified by the neer.					=
						,	
				<i>8</i> 7.			
	567(02-99) Previous Version	s Obsolete Event ID: GQ54	101	Facility ID: 00146		If continuation sh	Poot Doot 0

#### PRINTED: 08/08/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED 5403026 **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - 2007 CONNECTING LINK 245403 B. WING 07/12/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **105 GLENHAVEN DRIVE GOOD SAMARITAN SOCIETY - BATTLE LAKE** BATTLE LAKE, MN 56515 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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 (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE 08/04/2016

Electronically Signed

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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DEPART	FORM APPROVED							
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		_	0		0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245403	B. WING			07/1	12/2016	
NAME OF PROVIDER OR SUPPLIER			· · · · · ·	STR	EET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - BATTLE LAKE			105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
К 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/or responsible for com- prevent a reoccurre The facility was sur The Good Samarita 1-story building, wit building was built in be Type II(000) con- the south of the we north wing (Occupa OT/PT) were const were determined to In 2004 a small ves wing which include Type II (000) consti- link, to the new ass added to the south be Type V (111). In was constructed to which is 1-story, no construction. In 20	tate.mn.us (@state.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency veyed as two buildings. an Society Battle Lake is a thout a basement. The original n 1973 and was determined to astruction. In 1994 additions to st wing and to the north of the ational and Physical Therapy - ructed. The 1994 additions be Type V(111) construction. stibule was added to the west d a walk in freezer, which is ruction. In 2007 a connecting sisted living apartments, was wing and was determined to 2010 an entrance addition the north of the dining room b basement and Type II (000) 11 a 16 bed addition was	κc	000				
	be Type V (111). In was constructed to which is 1-story, no construction. In 20 added to the east of	2010 an entrance addition the north of the dining room basement and Type II (000)						

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NIEWENI				PLE CONSTRUCTION		SURVEY
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		B. WING		07/1	07/12/2016	
IAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 000	Continued From pa	ige 2	K 00	0		
	wing and was dete construction. The	I to the east of the south east rmined to be Type II (111) building is divided into 3 nts by 30 minute rated fire				
	system installed in Standard for the In (1999 edition). A fir smoke detection at areas which was u with NFPA 72 "The (1999 edition), that department notificat detection is provide	is sprinkler protected with a accordance with NFPA 13 stallation of Sprinkler Systems e alarm system with corridor nd smoke detection in common pdated in 2010 in accordance National Fire Alarm Code" is monitored for automatic fire ation. Additional automatic fire ed in accordance with the re Code (2007 edition).				
		apacity of 55 beds with a ents at the time of the				
K 038	NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD	K 03	8		8/3/16
SS=E	Exit access is so a accessible at all tin 18.2.1, 19.2.1	rranged that exits are readily nes in accordance with 7.1.				
	Based on observa determined that the three exterior exit of 101 Life Safety Co	is not met as evidenced by: tions and staff interview, it was e facility failed to maintain 1 of doors in accordance with NFPA de (00) edition, Section egress. During an evacuation		Facility Maintenance Director wi and install appropriate signage of door. Completion Date: August 3, 201	on noted	<b>*</b> .

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		AND HUMAN SERVICES				FORMA	APPROVED	
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPL		(X3) DATE	0938-0391 SURVEY	
AND PLAN OF CORRECTION				02 - 2007 CONNECTING LINK	COMPLETED			
245403			B. WING			07/12/2016		
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - BATTLE LAKE					05 GLENHAVEN DRIVE			
			ID	D	ATTLE LAKE, MN 56515 PROVIDER'S PLAN OF CORRECTIO	N	(X5) COMPLETION	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	(EACH CORRECTIVE ACTION SHOULD	(EACH CORRECTIVE ACTION SHOULD BE CO CROSS-REFERENCED TO THE APPROPRIATE		
K 038	<ul> <li>K 038 Continued From page 3 Findings include:</li> <li>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.</li> </ul>		ĸ	038				
	This deficient cond Maintenance Engin	ition was verified by the leer.						
	×.							
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