DEPARTMENT OF HEAL	FH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDIC.	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: GUEP
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00021
1. MEDICARE/MEDICAID PROVI	DER NO.	3. NAME AND AL			ACUDUCU	4. TYPE OF ACTION: <u>7 (</u> L8)
(L1) 245600	NO	(L3) GOOD SAM (L4) 172 SUMMI			LACKDUCK	1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID (L2) 336240000	NU.	(L4) 172 SUMINI (L5) BLACKDU		LS1	(L6) 56630	3. Termination 4. CHOW 5. Validation 6. Complaint
			,			7. On-Site Visit 9. Other
 EFFECTIVE DATE CHANGE OF (L9) 	- OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
)2/2016 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	10 I (I 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	(===)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11. LTC PERIOD OF CERTIFICATIO	ON	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :		Program Re	equirements		2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	30 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
13.Total Certified Beds	30 (L17)	B. Not in Comp	liance with Progr	am	5. Life Safety Code	9. Beds/Room
		-	and/or Applied		* Code: A*	(L12)
14. LTC CERTIFIED BED BREAKD	OWN	•			15. FACILITY MEETS	
18 SNF 18/19 SNF	5 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
30						
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE Lyla Burkman, Unit Su	nervisor	Date :	06/28/2016		18. STATE SURVEY AGENCY	
	•			(L19)		(L20)
					OFFICE OR SINGLE S	DIATE AGENCY
19. DETERMINATION OF ELIGIB	ILITY		IPLIANCE WIT	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to	Participate				3. Both of the Above	
2. Facility is not Eligib	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLUNTARY</u>
04/01/1992					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspensio	n of Admissions:			04-Other Reason for Withdrawal	07-Flovidel Status Change
(L27)	D.D. 1.10		(L44)			00-Active
	B. Rescind S	uspension Date:	(7.4.7)			
28. TERMINATION DATE:	20	9. INTERMEDIARY/	(L45)		30. REMARKS	
20. TERMINATION DATE.	23		CINCILICITY.		SV. NEAR INKS	
	(1.28)	00140		(L31)		
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)	06/01/2016		(L33)	DETERMINATION APP	ROVAL
	. /			. /		

FORM CMS-1539 (7-84) (Destroy Prior Editions)



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245600

July 12, 2016

Mr. Adam Coe, Administrator Good Samaritan Society - Blackduck 172 Summit Avenue West Blackduck, Minnesota 56630

Dear Mr. Coe:

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 June 15, 2016 the above facility is certified for:

30 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 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 June 28, 2016

Mr. Adam Coe, Administrator Good Samaritan Society - Blackduck 172 Summit Avenue West Blackduck, Minnesota 56630

RE: Project Number S5600025

Dear Mr. Coe:

On April 27, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 21, 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 June 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 17, 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 April 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 21, 2016, effective June 15, 2016 and therefore remedies outlined in our letter to you dated April 27, 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,

Mart meeth

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVISI	Т
IDENTIFICATION NUMBER	A. Building				
245600 _{Y1}	B. Wing	Y	2	6/2/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY	- BLACKDUCK	172 SUMMIT AVENUE WEST			
		BLACKDUCK, MN 56630			

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	ITEM	
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix F0329	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC	05/17/2016	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		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
REVIEWED BY STATE AGENCY X	REVIEWED BY (INITIALS) LB/mm	DATE 06/28/2016	SIGNATURE OF SURVEYOR 28035		DATE 06/02	/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 4/21/2016			RANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-2567	NCIES. WAS A) SENT TO THI		s 🗌 no

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245600 _{Y1}	B. Wing	Y2	6/17/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - BI	_ACKDUCK	172 SUMMIT AVENUE WEST		
		BLACKDUCK, MN 56630		

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
Reg. #	FPA 101 0029	Correction Completed 06/01/2016	ID Prefix Reg. # NFPA 1 LSC K0144	01 Correction 02 Completed 06/01/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
REVIEWED E STATE AGEN REVIEWED E CMS RO FOLLOWUP	NCY 🔀	REVIEWED BY (INITIALS) TL/mm REVIEWED BY (INITIALS)		SIGNATURE OF SURVEYOR 36536 TITLE ANY UNCORRECTED DEFICIENCIES FED DEFICIENCIES (CMS-2567) SEN		DATE 06/17/2016 DATE

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building 02 - ACTIVITIES ADDITION			
245600 _{Y1}	B. Wing	Y2	6/17/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - BI	_ACKDUCK	172 SUMMIT AVENUE WEST		
		BLACKDUCK, MN 56630		

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).

ITE	м	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix Reg. # LSC	NFPA 101 K0056	Correction Completed 06/15/2016	ID Prefix Reg. # NFPA 1 LSC K0144	01 Correction 02 Completed 06/01/2016	ID Prefix Reg. # 	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) TL/mm REVIEWED BY (INITIALS) DMPLETED ON		SIGNATURE OF SURVEYOR 365 TITLE ANY UNCORRECTED DEFICIENCIES	S. WAS A SUMMARY OF	DATE 06/17/2016 DATE
4/21/2016	6		UNCORRECT	TED DEFICIENCIES (CMS-2567) SEN	T TO THE FACILITY?	YES NO

DEPARTMENT OF HEAL	FH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVIC	ES
	MEDICA	ARE/MEDICAL	D CERTIFICA	ATION A	AND TRANSMITTAL	ID: GUEP	
	PART I -	TO BE COMPI	LETED BY TI	HE STAT	TE SURVEY AGENCY	Facility ID: 00021	
MEDICARE/MEDICAID PROVID (L1) 245600 2.STATE VENDOR OR MEDICAID		3. NAME AND AI (L3) GOOD SAM (L4) 172 SUMMI	IARITAN SOCI	IETY - BI	LACKDUCK	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW	on
(L2) 336240000		(L5) BLACKDU	CK, MN		(L6) 56630	5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 04/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	21/2016 (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 DATE: (L3 12/31	5)
11LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF	30 (L18) 30 (L17) OWN	Compliance 1. A X B. Not in Con		am	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	7. Medical Director	
30							
(L37) (L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE Vienna Andresen, HFB	E NEII	Date : 0	05/10/2016	(L19)	18. STATE SURVEY AGENCY Mark Mee Enforcement Spe	ith	16 (L20)
PA	ART II - TO BE	COMPLETED I	BY HCFA RE	GIONAL	OFFICE OR SINGLE S	TATE AGENCY	
 19. DETERMINATION OF ELIGIB <u>X</u> 1. Facility is Eligible to <u>2</u>. Facility is not Eligible 	Participate		IPLIANCE WITH HTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	ENT	26. TERMINATION ACTION	: (L30)	
OF PARTICIPATION 04/01/1992	BEGINNINC	6 DATE	ENDING DATI	Е	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change 00-Active	
	B. Reschiu Si	ispension Date.	(1.45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	(L45)		30. REMARKS		
		00140					
	(L28)	00140		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL I	DATE			
	(L32)	06/01/2016		(L33)	DETERMINATION APP	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 27, 2016

Mr. Gordon Hormann, Administrator Good Samaritan Society - Blackduck 172 Summit Avenue West Blackduck, Minnesota 56630

RE: Project Number S5600025

Dear Mr. Hormann:

On April 21, 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:

Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: Lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

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 May 31, 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 May 31, 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 - Blackduck April 27, 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 July 21, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

Good Samaritan Society - Blackduck April 27, 2016 Page 5 issued This mandatory denial of paym

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 October 21, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <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:

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

Email: tom.linhoff@state.mn.us Phone: (651) 430-3012 Fax: (651) 215-0525 Good Samaritan Society - Blackduck April 27, 2016 Page 6 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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C		. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245600	B. WING		04/	/21/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	AMARITAN SOCIETY			172 SUMMIT AVENUE WEST		
GOOD 3/	AMANITAN SOCIETT	BLACKDOCK		BLACKDUCK, MN 56630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	ס		
	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 nic submission of the POC will cion of compliance.				
F 329 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 EGIMEN IS FREE FROM RUGS	F 329	9		5/17/16
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of neces which indicate the dose or discontinued; or any e reasons above.				
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not inless antipsychotic drug ry to treat a specific condition documented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these				
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					05/06/2016

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

PRINTED: 05/09/2016

TAG FEGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 329 Continued From page 1 drugs. F 329 F 329 F 329 F 329 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an antianxiety medication had been tapered for 1 of 2 residents (R18) who received anti-anxiety medication without persistent symptoms of anxiety identified. F 329 On 4-28-16 A dose reduction was requested for antianxiety medication for R18. Documentation for behavior symptoms is being charted in R18 medical record as the behaviors occur. Medical records for all residents receiving psychoactive medication will be reviewed for latest dose reductions documentation of behavioral symptoms and reductions will be requested from physician if indicated. Documentation of behavior symptoms will be documented in each indicated. Documentation of behavior symptoms will be documented in each indicated. Documentation of behavior symptoms will be documented in each indicated. Documentation will be reviewed from physician if indicated. Documentation will be reviewed with all nursing staff. Behavior committee will meet a minimum of monthly to review psychoactive medications. DNS or designee will complete random audits of residents medical records for			AND HUMAN SERVICES			FORM	APPROVED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - BLACKDUCK T2 SUMMAR VEST BLACKDUCK, NN 56630 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) 00 (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) 00 (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) 00 (EACH CORRECTIVE ACTI	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	E SURVEY
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GOOD SAMARITAN SOCIETY - BLACKDUCK BLACKDUCK, MN 56630 Image: Summary statement of Descrictions (EACC Defections will be redications will be reviewed to heavior symptoms or delusions. preserve and state of the symptoms of anxiety identified. preserve and state of the symptoms or delusions. preserve and symptoms or delusions.	NAME OF F	PROVIDER OR SUPPLIER					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DEFICIENCY) COMPLETE DEFICIENCY) COMPLETE DEFICIENCY) F 329 Continued From page 1 drugs. F 329 F 329 On 4-28-16 A dose reduction was requested for antianxiety medication had been tapered for 1 of 2 residents (R18) who received anti-anxiety medication without persistent symptoms of anxiety identified. On 4-28-16 A dose reduction was requested for antianxiety medication for R18. Documentation for behavior symptoms is being charted in R18 medical record as the behaviors occur. Medical record so for all residents receiving psychoactive medications will be reviewed for latest dose reductions documentation of behavioral symptoms and reductions will be requested for matrixiety medication for latest dose reductions documentation of behavioral symptoms and reductions will be documented in each individual record as the symptoms occur. Appropriate behavior commentation will be reviewed with all nursing staff. Behavior committee will meet a minimum of monthy to review psychoactive medications. DNS or designee will complete random audits of residents medical records for	GOOD S	AMARITAN SOCIETY	- BLACKDUCK				
drugs.drugs.This REQUIREMENT is not met as evidenced by:Based on interview and document review, the facility failed to ensure an antianxiety medication had been tapered for 1 of 2 residents (R18) who received anti-anxiety medication without persistent symptoms of anxiety identified.On 4-28-16 A dose reduction was requested for antianxiety medication for R18. Documentation for behavior symptoms is being charted in R18 medical records for all residents receiving psychoactive medications documentation of behavior symptoms and reductions will be requested from physician if indicated R18's Admission Record dated 4/21/16, indicated R18 was admitted to the facility with diagnoses of dementia with behavior symptoms, anxiety, chronic pain syndrome, and fibromyalgia.On 4-28-16 A dose reduction was requested for antianxiety medication for R18. Documentation for behavior symptoms is being charted in R18 medical records for all residents receiving psychoactive medications documentation of behavioral symptoms and reductions will be requested from physician if individual record as the symptoms occur. Appropriate behavior documentation will be bereviewed with all nursing staff. Behavior committee will meet a minimum of monthly to review psychoactive medications and behavior symptoms to determine continued need for the medications. DNS or designee will complete random audits of residents medical records for	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
by: Based on interview and document review, the facility failed to ensure an antianxiety medication had been tapered for 1 of 2 residents (R18) who received anti-anxiety medication without persistent symptoms of anxiety identified.On 4-28-16 A dose reduction was requested for antianxiety medication for R18. Documentation for behavior symptoms is being charted in R18 medical records for all residents receiving psychoactive medications will be reviewed for latest dose reductions documentation of behavioral symptoms and reductions will be requested from physician if indicated. Documentation of behavior symptoms will be documented in each individual record as the symptoms cocur. Appropriate behavior documentation will be reviewed with all nursing staff. Behavior symptoms or delusions.R18's quarterly Minimum Data Set (MDS) dated 2/4/16, indicated R18 had severe cognitive impairment and displayed no inappropriate behavior symptoms or delusions.Cn 4-28-16 A dose reduction was requested for antianxiety medication for R18. Documentation for behavior symptoms is being charted in R18 medical records for all residents receiving psychoactive medications will be reviewed symptoms will be documented in each individual record as the symptoms occur. Appropriate behavior documentation will be reviewed with all nursing staff. Behavior symptoms to determine continued need for the medications. DNS or designee will complete random audits of residents medical records for	F 329		ge 1	F 32	9		
R18's physician orders dated 4/14/16, indicated behavior documentation and dose R18 received the anti-anxiety medication Ativan reductions monthly X 3 months. Audit 0.5 mg by mouth every day for unspecified results will be reviewed by Quality anxiety since 9/9/15, and a tapering had not been committee for further recommendations. Review of the manufacturer's package insert for Review of the manufacturer's package insert for		by: Based on interview facility failed to ensu- had been tapered for received anti-anxiet persistent symptom The findings include R18's Admission Re R18 was admitted t dementia with beha chronic pain syndro R18's quarterly Min 2/4/16, indicated R ⁻¹ impairment and dis behavior symptoms R18's physician ord R18 received the au 0.5 mg by mouth eva anxiety since 9/9/15 attempted.	and document review, the ure an antianxiety medication or 1 of 2 residents (R18) who by medication without is of anxiety identified. ecord dated 4/21/16, indicated o the facility with diagnoses of wor symptoms, anxiety, me, and fibromyalgia. imum Data Set (MDS) dated 18 had severe cognitive played no inappropriate or delusions. Hers dated 4/14/16, indicated nti-anxiety medication Ativan very day for unspecified 5, and a tapering had not been		requested for antianxiety medication R18. Documentation for behavior symptoms is being charted in R18 medical record as the behaviors of Medical records for all residents re- psychoactive medications will be re- for latest dose reductions documen of behavioral symptoms and reduct will be requested from physician if indicated. Documentation of behav symptoms will be documented in ea- individual record as the symptoms Appropriate behavior documentation be reviewed with all nursing staff. Behavior committee will meet a min of monthly to review psychoactive medications and behavior symptom determine continued need for the medications. DNS or designee will complete ran- audits of residents medical records behavior documentation and dose reductions monthly X 3 months. Au results will be reviewed by Quality	ccur. ceiving eviewed ntation tions vior ach occur. on will nimum ns to dom a for udit	

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

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES & MEDICAID SERVICES	•				ORM APPROVED NO. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		245600	B. WING				04/21/2016
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP C	CODE	
GOOD S	AMARITAN SOCIETY	- BLACKDUCK			UMMIT AVENUE WEST CKDUCK, MN 56630		
(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)	SHOULD BE	E (X5) COMPLETION DATE
F 329		ge 2 r continued use not longer	F 3	29			
	from 5/1/15-4/21/16 on 2/15/16, the pha physician evaluate Ativan 0.5 mg every reduction to 0.25 m comments section of "addressed by MD rationale document regimen review rep	onthly drug regimen reviews b, were reviewed and identified rmacist recommended the the continued need for the y night, and consider a g every night. The follow-up of the form included & rejected." There was no ed on the pharmacist drug ort that indicated the reason ommendation had not been					
	progress note dated following related to Ativan and does we interested in chang does not seem to b had not identified cl continued use of th	e reviewed. The physician d 4/11/16, revealed the the use of Ativan: R18 is on ell on these and I would not be ing at this point. R18's mood e a difficulty. The physician inical rationale for the e medication. No other notes were provided that					
	the following related medication: R18 us medications related and has a history of agitated and becom family visits and be	t revised on 2/1/16, identified d to the use of anxiolytic ses pharmacological I to the diagnosis of anxiety f aggressive behavior, is easily nes restless. R18 forgets when lieves family never visits. The e the following: Per doctor					

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

If continuation sheet Page 3 of 4

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	05/09/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245600	B. WING		04/:	21/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	SAMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(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 329	recommendation or be made to medica to healthcare provid reactions to psycho non-pharmacologic or restless: speak in and use distraction involved in an activi quiet area and look The behavior monit from 9/1/15-5/14/16 On 9/16/15, a progr hollering for mom w was again hollering R18 was yelling out R18 used her call li- bathroom. Nursing assistant (f 4/21/16, at 1:32 p.m and stated R18 cou times R18 had not of inappropriate behave On 4/21/2016 at 8: was interviewed and documentation had behavior symptoms the continued use of	n January 2016-No changes ation. Monitor record and report der side effects and adverse bactive medication. Attempt cal approaches: When agitated in a calm manner, offer coffee by changing subject or getting rity. Take the resident to a calm a tfamily pictures and visit. toring for R18 was reviewed 6, which revealed the following: ress note indicated R18 was while sleeping. 11/3/15, R18 g in her sleep. On 11/23/15, t while sleeping. On 12/5/15, ight many times to go to the NA)-A was interviewed on n. regarding R18's behavior uld be grouchy and abrupt at displayed any other vior symptoms. :38 a.m. the director of nursing id confirmed R18's behavior and the medication nor had a tivan had not been attempted	F 329			

If continuation sheet Page 4 of 4

		AND HUMAN SERVICES & MEDICAID SERVICES		Fr	61 00001	FORM): 05/10/2016 1 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPL	E CONSTRUCTION 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245600	B. WING			04	/21/2016
NAME OF F	PROVIDER OR SUPPLIER		. <u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK			72 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(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
K 000	INITIAL COMMENT	S	КC	000			
	FIRE SAFETY						A
	01 Main Building						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	DC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR E BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
1	ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL CO! REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION.					
	Minnesota Departm Marshal Division. At Samaritan Society E was found not in sub requirements for par Medicare/Medicaid a 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart ty from Fire, and the 2000 ire Protection Association 1, Life Safety Code (LSC),			EDOO	7	
	PLEASE RETURN 1 CORRECTION FOR DEFICIENCIES (K 1 Health Care Fire Ins State Fire Marshal D 445 Minnesota Stree	R THE FIRE SAFETY FAGS) TO: pections Division			EPOC		
	St. Paul, MN 55101						
	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE 05/06/2016

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

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA). 0938-03 TE SURVEY
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING	3 01 - MAIN BUILDING 01	со	MPLETED
		245600	B. WING		04	/21/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOODS	AMARITAN SOCIET			172 SUMMIT AVENUE WEST		
		DEAGRADOOR		BLACKDUCK, MN 56630		
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETI DATE
K 000	Continued From pa	age 1	K 000			
	Or by e-mail to: Marian.Whitney@s and Angela.Kappenma					
-		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:				
	1. A description of to correct the defic	what has been, or will be, done iency.				
	2. The actual, or pr	oposed, completion date.				
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency				
	building built at three major portion of the 1-story with a base be Type I(332) con- room/ PT addition w the original building a basement and wa (111) construction. activities addition w the dining room. It is barrier, 1-story, no	bociety Blackduck is a 1-story be different times. The first and be building was built in 1970, is ment and was determined to struction. In 1996 a dining was constructed to the north of p. This addition is 1-story, with as determined to be type II In 2009 a connecting link and vas constructed to the north of s separated with a 2-hour fire basement, Type V(111) is divided into 3 smoke zones barriers.		x		
1	sprinkler system wi installed in accorda	omplete automatic fire th quick response heads, nce with NFPA 13 The ation of Sprinkler Systems				

Facility ID: 00021

If continuation sheet Page 2 of 5

a fact of a second s		AND HUMAN SERVICES		FORM): 05/10/201 1 APPROVE 0. 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION (X3) DAT	TE SURVEY MPLETED
		245600	B. WING	/21/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630	
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 000	1999 edition. The f which includes smo corridor system and is installed in accor National Fire Alarm sleeping rooms hav operated smoke de have automatic fire the Minnesota State fire alarm system is department notifica	acility has a fire alarm system bke detection throughout the d in all common areas, which dance with NFPA 72 "The Code" 1999 edition. All ve single station battery tectors and hazardous areas detection in accordance with e Fire Code 2007 edition. The monitored for automatic fire tion.	К 00	0	
K 029 SS=E	NOT MET. NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syster and/or 19.3.5.4 prot the approved autom option is used, the a other spaces by sm doors. Doors are so field-applied protect 48 inches from the permitted. 19.3.2 This STANDARD is Based on observat revealed that the fac proper protection fro areas located throug accordance with NF (2000 edition) sectio conditions could in t	s not met as evidenced by: ions and staff interview, it was cility has failed to provide om 1 of several hazardous	K 02	9 Spring hinges will be installed on Room 108's door. All other rooms designated as storage will be checked for closers. Maintenance will be responsible to install closers on doors for any room designated as storage in the future. Quality meeting to review.	6/1/16

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Event ID: GUEP21

Facility ID: 00021

If continuation sheet Page 3 of 5

TATEMEN	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF	PLE CONSTRUCTION (X3) [IO. 0938-039 DATE SURVEY OMPLETED	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING 01 - MAIN BUILDING 01		COMPLETED	
		245600	B. WING	WING 04		
NAME OF	PROVIDER OR SUPPLIER	A.		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 029	untenable, which co exiting capabilities an undetermined an Findings include: On the facility tour I on 04/21/2016 obse revealed a missing	age 3 ent areas making them build negatively affect the for 14 of the 27 residents and mount of staff and visitors. Detween 8:30 am to 12:00 pm ervations and staff interview closer on storage room 108 in	K 029			
K 144 SS=F	Director of Mainten NFPA 101 LIFE SA Generators inspect under load for 30 m in accordance with 3-4.4.1 and 8-4.2 (N 110) This STANDARD is Based on review of the facility failed to generator in accord NFPA 110 - 1999 ec edition, section 3-4. could affect the safe	ition was verified by the ance. FETY CODE STANDARD ed weekly and exercised inutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA s not met as evidenced by: f records and staff interview, maintain the emergency ance with the requirements of dition and NFPA 99 - 1999 1.1.2. This deficient practice ety of all 27 residents and an unt of staff and visitors.	K 144	Generator runs automatically - start- run cool down Cool down will be logged on monthly tes logs Maintenance is responsible to complete the monthly log. Safety committee to complete audits monthly X 3 to ensure logs are complete Audits to Quality committee for further recommendations.	t	
	04/21/2016 record r	between 8:30 to 12:00 on review and staff interview ator cool down cycle was not pred.				

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

Event ID: GUEP21

Facility ID: 00021

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES	r		OMB NO	APPROVE 0. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - Main Building 01		TE SURVEY MPLETED	
		245600	B. WING		04	/21/2016	
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODI			
good s	AMARITAN SOCIETY	- BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630				
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
K 144	Continued From pa This deficient pract of Maintenance.	age 4 tice was verified by the Director	K 144		1		
		÷					
	7(02-99) Previous Versions			lity ID: 00021 If co	ntinuation she		

		AND HUMAN SERVICES	Ŧ	5600026 0	FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION NG 02 - ACTIVITIES ADDITION	(X3) DATE SURVEY COMPLETED
		245600	B. WING _		04/21/2016
NAME OF F	PROVIDER OR SUPPLIER	hn .	_	STREET ADDRESS, CITY, STATE, ZIP CODE 172 SUMMIT AVENUE WEST	
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		BLACKDUCK, MN 56630	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / 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)	D BE COMPLETION
K 000	INITIAL COMMENT	ſS	K 00	00	
	FIRE SAFETY				
	02 2009 Addition				
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.			
	ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL COI REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE IS BEEN ATTAINED IN TH YOUR VERIFICATION.			
	Minnesota Departm Marshal Division. At Samaritan Society E addition was found i with the requiremen Medicare/Medicaid 483.70(a), Life Safe edition of National F	ty from Fire, and the 2000 ire Protection Association 01, Life Safety Code (LSC),			
	PLEASE RETURN CORRECTION FOR DEFICIENCIES (K	R THE FIRE SAFETY		EPC :	
	Health Care Fire Ins State Fire Marshal I 445 Minnesota Stree St. Paul, MN 55101	Division			
		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	(X6) DATE
Electroni	cally Signed				05/06/2016

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - ACTIVITIES ADDITION B. WING 245600 04/21/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **172 SUMMIT AVENUE WEST GOOD SAMARITAN SOCIETY - BLACKDUCK** BLACKDUCK, MN 56630 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 Continued From page 1 K 000 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society Blackduck is a 1-story building built at three different times. The first and major portion of the building was built in 1970, is 1-story with a basement and was determined to be Type I(332) construction. In 1996 a dining room/ PT addition was constructed to the north of the original building. This addition is 1-story, with a basement and was determined to be type II (111) construction. In 2009 a connecting link and activities addition was constructed to the north of the dining room. It is separated with a 2-hour fire barrier, 1-story, no basement, Type V(111) construction facility is divided into 3 smoke zones with 30-minute fire barriers. The facility has a complete automatic fire sprinkler system with quick response heads, installed in accordance with NFPA 13 The Standard for Installation of Sprinkler Systems FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 2 of 5 Event ID: GUEP21 Facility ID: 00021

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES		OMB N	O. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		245600	B. WING	0	4/21/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	(- BLACKDUCK		BLACKDUCK, MN 56630	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 000	1999 edition. The which includes smo corridor system an is installed in accor National Fire Alarm sleeping rooms ha operated smoke de have automatic fire the Minnesota Stat fire alarm system is department notifica The facility has a c census of 27 at the	facility has a fire alarm system oke detection throughout the d in all common areas, which rdance with NFPA 72 "The o Code" 1999 edition. All ve single station battery etectors and hazardous areas a detection in accordance with e Fire Code 2007 edition. The s monitored for automatic fire	К 000		
K 056 SS=F	There is an automa in accordance with Installation of Sprin components, device complete coverage Systems are equipy switches, which are system. In Type I at protection measure substituted for sprin areas where State sprinklers. 18.3.5, 1 This STANDARD is Based on observat found that the autor installed in accorda Standard for the Ins (99). The failure to compliance with NF	FETY CODE STANDARD atic sprinkler system installed NFPA13, Standard for the kler Systems, with approved e and equipment, to provide of all portions of the facility. bed with waterflow and tamper e connected to the fire alarm nd II construction, alternative as shall be permitted to be hkler protection in specific or local regulations prohibit 18.3.5.1. s not met as evidenced by: tions and staff interview, it was matic sprinkler system is not ance with NFPA 13 the stallation of Sprinkler Systems install the sprinkler system in FPA 13 (99) could create a protection system capability in	K 056	On 4-25-2016 Nova Fire Protection at facility to assess the job requirements. Nova fire Protection to install sprinkler heads in attic and below ceiling of canopy of the east exit. Maintenance is responsible to maintain contact with Nova Fire Protection for	6/15/16

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

Event ID: GUEP21

Facility ID: 00021

If continuation sheet Page 3 of 5

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 02 - ACTIVITIES ADDITION		E SURVEY	
		245600	B. WING		04/	04/21/2016	
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
GOOD S	AMARITAN SOCIETY	- BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE	
K 056		age 3 ergency that would affect all and staff of the facility.	K 05	6 scheduling the job and unt complete.	il job is		
	on 04/21/2016 observealed the attach	between 8:30 am to 12:00 pm ervations and staff interview ed canopy over the east exit of of combustible construction I.	74				
K 144 SS=F	of Maintenance. NFPA 101 LIFE SA Generators inspect under load for 30 m	ice was verified by the Director FETY CODE STANDARD ed weekly and exercised inutes per month and shall be	K 14	4		6/1/16	
	3-4.4.1 and 8-4.2 (N 110) This STANDARD is Based on review of the facility failed to generator in accord NFPA 110 - 1999 ef edition, section 3-4. could affect the safe	NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA s not met as evidenced by: f records and staff interview, maintain the emergency lance with the requirements of dition and NFPA 99 - 1999 1.1.2. This deficient practice ety of all 27 residents and an unt of staff and visitors.		Generator runs automatic cool down Cool down will be logged o logs Maintenance is responsible the monthly log. Safety committee to comp monthly X 3 to ensure logs Audits to Quality committee recommendations.	on monthly test e to complete lete audits are completed.		
	On the facility tour b 04/21/2016 record r	between 8:30 to 12:00 on review and staff interview ator cool down cycle was not bred.					

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

Event ID: GUEP21

Facility ID: 00021

If continuation sheet Page 4 of 5

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		TIPLE CONSTRUCTION NG 02 - ACTIVITIES ADDITION	(X3) DA CO	TE SURVEY	
		245600	B. WING		04	04/21/2016	
NAME OF P	ROVIDER OR SUPPLIE	ER		STREET ADDRESS, CITY, STATE, ZIP			
GOOD SA	MARITAN SOCIE	TY - BLACKDUCK		172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETI DATE	
		14					



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered April 27, 2016

Mr. Gordon Hormann, Administrator Good Samaritan Society - Blackduck 172 Summit Avenue West Blackduck, Minnesota 56630

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5600025

Dear Mr. Hormann:

The above facility was surveyed on April 18, 2016 through April 21, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

Good Samaritan Society - Blackduck April 27, 2016 Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308/2104 or meail: lyla.burkman@state.mn.us.

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

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

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

Minnesc	ta Department of He	alth					"THOVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/0 IDENTIFICATION NUMB	г р.		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00021	B. WI	IG		04/2	1/2016
NAME OF I	PROVIDER OR SUPPLIER	S	TREET ADDRESS,	CITY, STAT	E, ZIP CODE		
GOOD S	AMARITAN SOCIETY		72 SUMMIT AV LACKDUCK, N				
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2 000	Initial Comments		2 00	D			
	*****ATTEI	NTION*****					
	NH LICENSING	CORRECTION ORDER	۲				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall with a schedule of f the Minnesota Depa	Minnesota Statute, sec ction order has been is y. If, upon reinspectior iency or deficiencies cit ected, a fine for each vic be assessed in accorda ines promulgated by ru artment of Health.	sued n, it is red plation ance le of				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess		g elow. e to ered pon le will ne item				
	that may result fron orders provided tha the Department wit	hearing on any assess n non-compliance with t a written request is m hin 15 days of receipt o nt for non-compliance.	these ade to				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the elect nsure orders consisten artment of Health in 14-01, available at tate.mn.us/divs/fpc/prof e licensing orders are	t with				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTAT	FIVE'S SIGNATURE		TITLE		(X6) DATE 05/06/16

STATE FORM

If continuation sheet 1 of 7

Minnesc	ta Department of He	ealth			-	-
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE COMP	
		00021	B. WING		04/2	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		IMIT AVENUE DUCK, MN 56	WEST		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surve found that the defice herein are not corrected shall with a schedule of the Minnesota Dep Determination of with corrected requires of the survey of the second states of the second	hether a violation has been compliance with all				
	number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	e rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	o participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf te licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE 05/06/16

STATE FORM

If continuation sheet 1 of 7

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00021	_		04/	04/21/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
OOD S	AMARITAN SOCIETY			WEST			
		BLACKL	OUCK, MN 566				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 000	Continued From pa	age 1	2 000				
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for in indicate in the electronic cess, under the heading he date your orders will be electronically submitting to the nent of Health.					
	this Department's s and the following co Please indicate in y correction that you	0, and 21, 2016, surveyors of staff, visited the above provider orrection orders are issued. your electronic plan of have reviewed these orders, te when they will be completed					
	the State Licensing federal software. Ta	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for					
	column entitled "IE statute/rule out of of "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00021 NAME OF PROVIDER OR SUPPLIER STREET AE			E CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED		
		00021	B. WING		04/21/2016	
		DDRESS, CITY, S	04/21/2010			
	AMARITAN SOCIETY		MIT AVENUE	WEST		
		BLACKL	UCK, MN 566			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary al	21535		5/17/16	
	must be free from u unnecessary drug is A. in excessive therapy; B. for excessive C. without adec D. in the preser which indicate the o discontinued. In addition to the di part 4658.1310, the with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual, Long-Term Care Fa Department of Heal Health Care Financ This standard is inc available through th	quate indications for its use; or nce of adverse consequences lose should be reduced or rug regimen review required in e nursing home must comply le Interpretive Guidelines for egulations, title 42, section Appendix P of the State , Guidance to Surveyors for iccilities, published by the th and Human Services, ing Administration, April 1992. orporated by reference. It is le Minitex interlibrary loan te Law Library. It is not				
	by: Based on interview facility failed to ensu had been tapered for	and document review, the ure an antianxiety medication or 1 of 2 residents (R18) who y medication without		On 4-28-16 A dose reduction was requested for antianxiety medication f R18. Documentation for behavior symptoms is being charted in R18 me		

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00021		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING	04/21/2016			
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	•		
GOOD S	AMARITAN SOCIETY		IMIT AVENU IUCK, MN 5	-		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	
21535	Continued From pa	age 3	21535			
	persistent sympton The findings includ	ymptoms of anxiety identified. s include:		record as the behaviors occur. Medical records for all residents re psychoactive medications will be r for latest dose reductions docume of behavioral symptoms and reduc	reviewed entation	
	R18 was admitted dementia with beha	ecord dated 4/21/16, indicated to the facility with diagnoses of avior symptoms, anxiety, ome, and fibromyalgia.		will be requested from physician if indicated. Documentation of beha symptoms will be documented in e individual record as the symptoms Appropriate behavior documentati be reviewed with all nursing staff.	avior each s occur. ion will	
	2/4/16, indicated R	nimum Data Set (MDS) dated 18 had severe cognitive splayed no inappropriate s or delusions.		 Behavior committee will meet a m of monthly to review psychoactive medications and behavior sympto determine continued need for the medications. DNS or designee will complete ran 	ms to ndom	
	R18 received the a 0.5 mg by mouth e	ders dated 4/14/16, indicated Inti-anxiety medication Ativan very day for unspecified 5, and a tapering had not been		audits of residents medical record behavior documentation and dose reductions monthly X 3 months. results will be reviewed by Quality Committee for further recommend	e Audit	
	the medication Ativ	ufacturer's package insert for ran revealed a or continued use not longer				
	from 5/1/15-4/21/10 on 2/15/16, the pha physician evaluate Ativan 0.5 mg ever reduction to 0.25 m comments section "addressed by MD	onthly drug regimen reviews 6, were reviewed and identified armacist recommended the the continued need for the y night, and consider a ng every night. The follow-up of the form included & rejected." There was no ted on the pharmacist drug	1			

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00021		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		04/21/2016		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		MIT AVENUE V UCK, MN 566			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 4	21535			
		oort that indicated the reason ommendation had not been				
	progress note date following related to Ativan and does we interested in chang does not seem to b had not identified c continued use of th	re reviewed. The physician d 4/11/16, revealed the the use of Ativan: R18 is on ell on these and I would not be ing at this point. R18's mood be a difficulty. The physician linical rationale for the re medication. No other notes were provided that				
	the following related medication: R18 u medications related and has a history of agitated and become family visits and be interventions include recommendation of be made to medicat to healthcare provise reactions to psychet non-pharmacologic or restless: speak i and use distraction involved in an active	et revised on 2/1/16, identified d to the use of anxiolytic ses pharmacological d to the diagnosis of anxiety f aggressive behavior, is easily nes restless. R18 forgets wher lieves family never visits. The de the following: Per doctor n January 2016-No changes ation. Monitor record and repor der side effects and adverse pactive medication. Attempt cal approaches: When agitated n a calm manner, offer coffee by changing subject or getting ity. Take the resident to a calm a tamily pictures and visit.	t			
nnesota D	from 9/1/15-5/14/16	toring for R18 was reviewed 6, which revealed the following ress note indicated R18 was	:			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00021				(X3) DATE SURVEY COMPLETED		
		B. WING		04/	04/21/2016	
AME OF PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STATE, ZIP CODE				
OOD SAMARITAN SOCIETY		IMIT AVENUE V DUCK, MN 566	-			
REFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535 Continued From pa	age 5	21535				
was again hollering R18 was yelling ou	vhile sleeping. 11/3/15, R18 i in her sleep. On 11/23/15, t while sleeping. On 12/5/15, ight many times to go to the					
4/21/16, at 1:32 p.n and stated R18 cou	NA)-A was interviewed on n. regarding R18's behavior Ild be grouchy and abrupt at displayed any other vior symptoms.					
was interviewed an documentation had behavior symptoms the continued use of	38 a.m. the director of nursing d confirmed R18's behavior I not shown ongoing anxious s which justified the need for of the medication nor had a tivan had not been attempted tarted on 9/9/15.					
identify all residents medication and det of the medications for it's use. The dire could review and/or related to monitorin appropriate taperin re-educated on the An auditing tool cou being shared with t	of Correction: sing and/or designee could s who use anxiolytic remine those needing tapering and appropriate justification ector of nursing or a designee r revise policies/procedures ag anxiolytic medications for g. All nursing staff could be se policies and procedures. uld be developed, with results he facility's quality assessmen mittee, to ensure ongoing					
Time Period For Co	prrection: Twenty-one (21)					

STATEMENT OF DEFICIENCIES (X1) PROVIDE AND PLAN OF CORRECTION (X1) PROVIDE IDENTIFIC 00021		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00021	B. WING	B. WING		04/21/2016	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
OOD S	AMARITAN SOCIETY		MIT AVENUE V DUCK, MN 566				
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
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	days.						
	-						