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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IBPJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**
2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/10/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)
13.Total Certified Beds **32** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, Unit Supervisor 1/7/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 1/7/2022 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 7, 2022

CMS Certification Number (CCN): 245278

Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

Dear Administrator:

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

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

Effective December 3, 2021 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 7, 2022

Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

RE: CCN: 245278
Cycle Start Date: October 21, 2021

Dear Administrator:

On December 30, 2021, we notified you a remedy was imposed. On December 10, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 3, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 21, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 30, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 21, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 3, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

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(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/21/2021** (L34)

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2 AOA 3 Other

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02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Koch, HFE NE II 12/08/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/20/2021 (L20)

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

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____ 2. Facility is not Eligible
(L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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04/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	C 10/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/18/21 through 10/21/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		11/23/21

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

Electronically Signed | 11/23/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	C 10/21/2021

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

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E 041	Continued From page 1	E 041		

must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]
The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	C 10/21/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition) Life Safety Code, section 9.1.3.1 and	E 041	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 3 NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1 through 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 10/25/2021 at 9:30 AM, during the review of all available emergency generator maintenance and testing documentation, it was revealed that the monthly generator run test was not documented for the month of November 2020. 2) On 10/25/2021 at 9:30 AM, during the review of all available emergency generator maintenance and testing documentation, it was revealed a weekly generator inspection was not completed on the week of December 31st, 2020. An interview with the Lead Maintenance Mechanic verified these deficient findings at the time of discovery.	E 041	alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. The facility will test and inspect the generator per NFPA 101 Life Safety Code. 2. The facility utilizes a building management software program called TELS to provide reminders of and to track compliance of regulatory tasks. Weekly and monthly generator inspection and testing are tasks that automatically deploy each week and month by the TELS system, assisting maintenance staff to be in compliance. 3. Administrator or designee will complete audits of weekly generator testing weekly x 4, then monthly x 3. Administrator or designee will complete audits of monthly generator testing monthly x 4. Audit results will be reviewed by the facility QAPI committee for further recommendations. 4. The Lead Maintenance Mechanic is responsible for correction and monitoring to prevent the reoccurrence of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 4	E 041	deficiency.	
F 000	INITIAL COMMENTS On 10/18/21 through 10/21/21, a standard recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). In addition, a complaint investigation was completed at the time of the recertification survey. Good Samaritan-Howard Lake was found not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be unsubstantiated: H5278013C/(MN00076426) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		12/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 5 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a	F 656	1. R4 and R13 now each have a comprehensive care plan. R4's care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 656	Continued From page 6 comprehensive care plan was developed and available to help outline services and care provided while on hospice for 1 of 1 residents (R4) reviewed for skin issues. Furthermore, the facility failed to ensure a comprehensive care plan was developed and available to help outline services and care provided while on hospice for 1 of 3 residents (R13) reviewed for communication / sensory issues. Findings include: R4's Admission Record (undated) indicated R4 had the diagnosis of a pilonidal cyst without abscess (cyst is usually located near the tailbone and can become easily infected). R4's annual Minimum Data Set (MDS), dated 7/21/21, indicated R4 was extensively dependent on staff for most of her activities of daily living and was severely cognitively impaired. In a review of the facility's wound measurement record, the area measured 0.5 centimeters (cm) x 0.50 cm x 0.1 cm). The physician orders, dated 9/15/21, directed the facility to "Monitor Pilonidal cyst on upper right buttocks every shift for [signs and symptoms] of infection, including erythema and warmth. The orders directed staff to keep covered with mepilex and continue to allow to drain. This was to be completed with every shift monitoring of draining cyst." In review of R4's Care Plan indicated concerns of the potential for Impaired Skin Integrity (last updated 5/6/21) and the potential for pressure ulcer development (last updated 7/21/21). However, the care plan lacked any documentation of R4's pilonidal cyst and the treatment ordered.	F 656	includes pilonidal cyst and R13's care plan includes that she is hard of hearing. 2. All current resident care plans will be reviewed to ensure they are comprehensive. 3. Training for MDS Coordinator on comprehensive care plans will be completed by Corporate MDS Consultant or Designee. All nurses will be educated on updating the care plan as necessary to ensure a comprehensive care plan is in place. Weekly Care Plan Review meetings will be held by the interdisciplinary team to review care plans to ensure they are comprehensive, according to the MDS schedule. 4. The DNS or designee will conduct audits of R4 and R13's care plans and 2 additional resident care plans each week x 4, then monthly x 3 to ensure care plans are comprehensive. The DNS or designee will conduct audits of the weekly care plan review meeting each week x 4, then monthly x 3 to ensure the meeting is being held (process put into place is being followed through). Audit results will be reviewed by the facility QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	C 10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 7	F 656		

R13's Admission Record (undated) indicated R13 had the diagnosis of dementia with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function). R13's admission MDS, dated 1/5/21, indicated R13 was extensively dependent on staff for most of her activities of daily living and was severely cognitively impaired.

In review of R13's In-House audiology services report, dated 5/25/21, indicated "possible decrease in hearing sensitivity bilaterally." The report indicated R13 "was wearing hearing aids upon arrival to appointment."

A review of R13's physician's orders in the electronic medical record (dated 5/29/21) documented:
"do NOT place bilateral hearing aides per audiologist. they do not work. Keep in med cart. every morning and at bedtime for hearing aid use."

In review of R13's Care Plan (last revised 8/24/21) lacked any indication R13 was hard of hearing and required hearing aids.

During interview on 10/21/21, at 10:32 a.m. the director of nursing (DON), after reviewing the care plans of both R4 and R13, stated she verified that neither R4's pilonidal cyst, nor R13's hearing difficulty had been addressed on their care plans. DON stated the missing information for both R4 and R13 would be important for facility staff to be aware of for the provision of care.

In review of the facility's policy, entitled: Care Plan

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F 656	Continued From page 8 - Rehab / Skilled (last revised 9/17/21) defined the Comprehensive Care Plan as: "includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The policy further indicated, under the definition of a Person-Centered Care as: "a focus on the resident as a [focus] of control and supporting the resident in making his / her own choices and having control over their daily life."	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676		12/3/21

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F 676	Continued From page 9 §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow up on audiology recommendations for communication ability of 1 of 1 resident (R13) who was hard of hearing with hearing aids requiring repair. Furthermore, the facility failed to follow up on optometrist recommendations for follow-up appointments of 1 of 1 resident (R20) who was reviewed for vision issues. Findings include: R13's Admission Record (undated) indicated R13 had the diagnosis of dementia with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function). R13's admission Minimum Data Set (MDS), dated 1/5/21, indicated R13 was extensively dependent on staff for most of her activities of daily living and was severely cognitively impaired. In review of R13's In-House audiology services report, dated 5/25/21, indicated R13 "was wearing hearing aids upon arrival to	F 676	1. The facility will follow up on audiology recommendations for R13, including attempting a PockeTalker type device. The facility will follow up on R20's optometrist recommendations for a follow-up appointment. 2. All residents' audiology and optometry appointments in the last 6 months, or since admission – whichever is sooner – will be reviewed to ensure recommendations and follow-ups (if necessary) have been followed up on. 3. A new process for follow-up from in-house services appointments such as audiology and optometry will be developed to ensure recommendations and follow-ups are completed. Training will be provided to all nurses on the new process by the DNS or designee. 4. The DNS or designee will conduct monthly audits of audiology and optometry appointments x 4 months, to ensure	

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F 676	Continued From page 10	F 676		

appointment." However, noting that the hearing aids were not functioning, the audiologist recommended the following:
"1. Attempt testing [noise volume] so as to hopefully be able to obtain new hearing aids for patient."
2. Use PocketTalker type device to aid patient in communication; this will be discussed with [Director of nursing]."

During a telephone interview on 10/20/21, at 9:03 a.m. R13's guardian (FM)-A stated she was aware R13's hearing aids were not working back in May 2021. However FM-A stated she was unaware of what the facility and / or the audiologist were doing about the repairs.

An interview on 10/20/21, at 12:47 p.m. registered nurse (RN)-A stated that R13 was not wearing the hearing aids while staff would frequently find R13's hearing aids in her mouth and chewing on them. RN-A stated the staff were concerned that R13 might swallow the batteries. RN-A knew the facility had PocketTalker devices, but was unaware if the device had been tried with R13.

A further interview on 10/20/21, 1:14 p.m. nursing assistant (NA)-A stated she was aware of R13's dementia and hearing difficulties. When asked how the facility staff communicated with R13, with NA-A stating they show R13 offer cares and needs by pointing to items. NA-A is unaware if a PocketTalker device has ever been tried with R13.

During an interview on 10/21/21, at 9:48 a.m. the director of nursing stated she had thought the previous Life Enrichment Director had attempted

follow-up has been completed. Audit results will be reviewed by the facility QAPI committee for further recommendations.

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F 676	Continued From page 11	F 676		

a trial with a PocketTalker device. However, after review of progress notes, there was no indication of that taking place.

R20's Admission Record (undated) indicated R20 had the diagnosis of glaucoma (group of eye conditions that damage the optic nerve). R20's significant change MDS, dated 4/6/21, indicated R20 had adequate vision, however, listed glaucoma as an active diagnosis. The MDS further indicated R20 was cognitively intact.

During interview on 10/18/21 2:57 p.m. R20 stated thought she had her vision checked over a year ago, but would like to go to the eye clinic in Cokato. R20 denied any current vision issues other than wishing a vision check and newer glasses.

In review of R20's physician's orders, it was documented that R20 received:
1. Combigan Solution (brimonidine tartrate) 0.2-0.5% (used to reduce pressure inside the eye used to treat glaucoma or ocular hypertension)
2. Lumigan Solution (bimatoprost) 0.01% (reduction of elevated intraocular pressure in patients with open angle glaucoma or ocular hypertension)

In review of R20's In-House vision exam services report, dated 3/22/21, indicated R20 "[return to clinic] 3 months for [intraocular pressure] check only."

In a review of R20's medical progress notes, there lacked evidence R20 was ever scheduled for the return visit to have her eye pressure re-evaluated.

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F 676	Continued From page 12 During an interview on 10/21/21, at 9:48 a.m. the director of nursing stated earlier in the year it was her understanding that R20 did not wish to go to her medical appointments, so both Hospice and the facility canceled them. However after review of R20's medical records, lacked documentation on whether the "return in 3 months" appointment was made and/or canceled. Although the facility had policies and procedures for the receiving and transcriptions of physician / other healthcare providers orders, the facility did not have a formal policy / procedure for appointment arrangements / cancellations.	F 676		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the primary provider reviewed the ongoing effectiveness of medications as recommended by the mental health consultant to ensure the highest practicable well-being was achieved for 1 of 1 residents (R1) reviewed for mood and behavior.	F 742	1. On 11/05/21, R1's primary provider reviewed the ongoing effectiveness of her medications as recommended by the mental health consultant from ACP. As a result of the review, R1's primary provider made changes to R1's medications on 11/05/21.	12/3/21

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F 742	Continued From page 13 Findings include: R1's annual Minimum Data Set (MDS) dated 7/14/21, identified diagnoses including depressive disorder , and a hemiplegia/hemiparesis (loss of mobility and/or function of one side of the body -stroke). The MDS indicated R1 was cognitively intact, and had not reported symptoms of depression or concerns regarding behavior. R1's care plan, revised on 8/2/21, printed on 10/21/21, identified R1 had depression related to disease process, functional impairments, and multiple comorbidities. R1's goal statement was for R1 to be free from signs and symptoms of distress, symptoms of depression, anxiety or sad mood. The care plan directed staff to seek consultation with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. It also identified talk therapy (counseling) biweekly (twice a month) with the Associated Clinic of Psychology (ACP/mental health care provider). During the initial interview on 10/19/21, at 9:30 a.m. when asked if they experienced depression or lack of interest in day to day activities, R1 responded, "That's my normal state." R1 went on to say watching TV took their mind off of their mood, however, they thought they were becoming, "immune" to the medications they were taking for their mood. R1 stated they met with a person for their mood and felt this helped. R1 was neat and well groomed in appearance. On 8/24/21, R1 was seen by licensed social worker (LSW)-A, from ACP. In the narrative note, R1's mood/affect was described as flat/depressed, and behavior as withdrawn and	F 742	2. All residents' ACP visit notes in the last 6 months, or since admission – whichever is sooner – will be reviewed to ensure recommendations (if necessary) have been followed up on. 3. Training regarding the process for review of ACP visit notes will be completed by DNS or designee. 4. The DNS or designee will conduct monthly audits of ACP visit notes x 4 months, to ensure recommendations (if necessary) have been followed-up on. Audit results will be reviewed by the facility QAPI committee for further recommendations.	

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F 742	Continued From page 14	F 742		

identified R1 remained "despondent," with a low mood. LSW-A identified R1 continued to have a low mood overall, and indicated, "examining the effectiveness of the current depression medication may be beneficial." This note was signed off as, "Noted" on 8/25/21 by registered nurse (RN)-B. An additional set of initials of LEC-A (Life Enrichment Coordinator) which lacked the date or other notation. On 9/28/21, R1 was again seen by LSW-A, and their mood/affect was again described as flat/depressed with withdrawn behavior. The note identified R1 continued to have days with chronic health issues which caused them to be "moody and fatigued." In the progress note, it indicated R1 shared with LSW-1 they were concerned others would feel they [R1] were "making it up" and "using it [their illness] as an excuse".

On 9/8/21, R1 was seen for routine follow up by their primary provider. In the 9/8/21 progress note, it identified R1 was seen for chronic medical conditions. The section titled Past Medical History identified R1 had a "major depressive disorder, recurrent, mild", however, it lacked review of current medications for treatment or their effectiveness.

During interview on 10/21/21, at 12:46 p.m. director of nursing (DON) indicated R1 had historically described their mood state as kind of a, "doom and gloom" attitude. DON stated upon review of the progress notes from the provider, it lacked documentation to reflect the medications prescribed for mood and behavior were reviewed for ongoing effectiveness. DON was unsure as to why the review of effectiveness of medications was not relayed to, and addressed by, the primary provider.

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F 742	Continued From page 15 A written policy was requested for the process of review and follow up on recommendations made by ACP but was not received. DON stated she could verbally provide the information for review of the ACP visit notes and follow up, however, did not have a written policy. DON stated the ACP progress notes were completed following the visit. The reports were then faxed to the facility in follow up and were received and reviewed by the LEC, and then passed onto to RN-B for review and follow up. Once this was completed, the dictated notes were provided to DON for review and follow up if indicated. DON stated this follow up had not been completed with the above listed notes.	F 742		

Electronically delivered
November 16, 2021

Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

RE: CCN: 245278
Cycle Start Date: October 21, 2021

Dear Administrator:

On October 21, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 January 21, 2022 (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).

In addition, if substantial compliance with the regulations is not verified by April 21, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society-Howard Lake was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/23/2021

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Good Samaritan Society-Howard Lake is a one-story building with no basement. The original building was constructed in 1971, with building additions constructed in 1983 and 1994. All buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire

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K 000	Continued From page 2 department notification. The facility has a capacity of 32 beds and had a census of 26 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4 through 19.7.1.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/25/2021 at 10:15 AM, it was revealed by a review of available documentation that the facility did not conduct and document the integrity of the alarm transmission during 6 of the last 12 months. These drills occurred during the Night	K 712	1. The facility will conduct fire drills per NFPA 101 Life Safety Code. A night shift fire drill was held on 11/11/2021. The fire panel monitoring transmission was checked the morning of 11/12/2021 and documented. All night shift fire drills moving forward will be performed in this same manner. 2. The Lead Maintenance Mechanic has now been properly trained to conduct and document the integrity of the fire alarm transmission for all shifts, including night shift fire drills. Verification of the fire panel	11/12/21

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K 712	Continued From page 3 Shift of the first quarter of 2021, the Night Shift of the second quarter of 2021, the Night Shift of the third quarter of 2021, and all shifts for the fourth quarter of 2020. An interview with the Lead Maintenance Mechanic verified this deficient finding at the time of discovery.	K 712	signal to the monitoring company will be documented on our fire drill paperwork, as well as the printed report from the monitoring company as back up. 3. The Administrator or designee will complete audits of the monthly fire drills monthly x 4, to ensure the integrity of the fire alarm transmission is conducted and documented. Audit results will be reviewed by the facility QAPI committee for further recommendations.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		11/23/21

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K 918	Continued From page 4 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 10/25/2021 at 9:30 AM, during the review of all available emergency generator maintenance and testing documentation, it was revealed that the monthly generator run test was not documented for the month of November 2020. 2) On 10/25/2021 at 9:30 AM, during the review of all available emergency generator maintenance and testing documentation, it was revealed a weekly generator inspection was not completed on the week of December 31st, 2020.	K 918	1. The facility will test and inspect the generator per NFPA 101 Life Safety Code. 2. The facility utilizes a building management software program called TELS to provide reminders of and to track compliance of regulatory tasks. Weekly and monthly generator inspection and testing are tasks that automatically deploy each week and month by the TELS system, assisting maintenance staff to be in compliance. 3. The Administrator or designee will complete audits of weekly generator testing weekly x 4, then monthly x 3. The Administrator or designee will complete audits of monthly generator testing monthly x 4. Audit results will be reviewed by the facility QAPI committee for further recommendations. 4. The Lead Maintenance Mechanic is responsible for correction and monitoring to prevent the reoccurrence of the deficiency.	

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K 918	Continued From page 5 An interview with the Lead Maintenance Mechanic verified these deficient findings at the time of discovery.	K 918		

Minnesota Department of Health: Protecting, maintaining improving the health of all Minnesotans.

Confirmation page! Thank you for using the data entry system.
If you have comments please send to:
monica.larson@state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **10/18/21** To F2: **10/21/21**	Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: **GOOD SAMARITAN SOCIETY - HOWAR**	Provider Number: **245278**	Fiscal Year ending:
Address: **413 13TH AVENUE, HOWARD LAKE, WRIGHT, MN 55349**		
Telephone Number: F6 **320-543-3800**	State/County Code: **MN / WRIGHT**	State/Region Code: **MN / 05**
A. F9 **03 - SNF/NF - Medicare/Medicaid** B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11		
Ownership: F12 **05 - Non Profit - Nonprofit Corporation**		
Owned or leased by Multi-Facility Organization: F13 **Yes** Name of Multi-Facility Organization: F14 **EvangelicalLutheranGoodSamaritanSociet**		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0** Huntington's Disease F21 **0** Other Spec Rehab. F23 **8**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0** Ventilator/Respiratory Care F22 **0**	
Does the facility currently have an organized resident group? F24		**Yes**
Does the facility currently have an organized group of family members of		**No**

residents? F25	
Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28 **NA**	Hours waived per week: F29 **NA**
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30 **NA**	Hours waived per week: F31 **NA**

Does the facility currently have an approved nurse aide training and competency program? F32	**No**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

Name of Person Completing Form: **Laura Salonek**	Date: **12/20/21**

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Spotlight

Minnesota eLicensing

Questions?

Please contact our Health Regulation Division: health.fpc-web@state.mn.us or 651-201-4101.

See also > Health Regulation

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651-201-5000 Phone
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Information on this website is available in alternative formats upon request.