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

					AND TRANSMITTAL	ID: L513
1. MEDICARE/MEDICAID PROVIDER (L1) 245278 2.STATE VENDOR OR MEDICAID NO. (L2) 608716700		 TO BE COMP 3. NAME AND AI (L3) GOOD SAM (L4) 413 13TH A (L5) HOWARD I 	DDRESS OF FACI IARITAN SOC AVENUE	LITY	TE SURVEY AGENCY WARD LAKE (L6) 55349	Facility ID: 00019 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OW (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	ORY 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 01/12/. 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 	(L34)	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: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b):		Complian		S:	And/Or Approved Waivers Of 7 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SI	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 13.Total Certified Beds	32 (L18)32 (L17)		mpliance with Prog and/or Applied Wa	-	5. Life Safety Code * Code: A*	9. Beds/Room (L12)
14. LTC CERTIFIED BED BREAKDOW. 18 SNF 18/19 SNF 32 (L37) (L38)	N 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMAR See Attached Remarks	KS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	3):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Michelle Thompson, HFE NE	II		01/25/2018	(L19)	Shellae Dietrich, Progra	m Assurance Supervisor 05/10/2018
PA	RT II - TO BE	COMPLETED	BY HCFA R		C OFFICE OR SINGLE S	
 DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Par <u>2</u>. Facility is not Eligible 			MPLIANCE WITH GHTS ACT:	CIVIL		ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) ve :
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION	(L30)
OF PARTICIPATION 04/01/1985	BEGINNING	DATE	ENDING DAT	ΓΕ	VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburser	00 INVOLUNTARY 05-Fail to Meet Health/Safety nent 06-Fail to Meet Agreement
(L24) 25. LTC EXTENSION DATE: (L27)	-	n of Admissions:	(L25) (L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	5
	B. Rescind Sus	pension Date.	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	DATE		
	(L32)	01/18/2018		(L33)	DETERMINATION APP	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: L513 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00019

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5278

On December 1, 2017, an extended survey was completed at this facility. The most serious deficiency (F-689) was cited at S/S level of J. Conditions in the facility at the time of the survey constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health and safety. The IJ began on November 28, and the Director of Nursing and Director of Environmental Services were notified on 11/29/17, at 5:06 p.m. The IJ was removed on 12/1/2017 at 2:19 p.m., however, non-compliance remained at an isolated scope and severity that indicated no actual harm with potential for more than minimal harm (Level D).

As a result of the survey findings, the Department imposed the Category 1 remedy of State Monitoring, effective December 20, 2017.

In addition, we recommended the CMS RO impose the following enforcement action:

-Civil Monetary Penalty for deficiency cited at F-689.

The facility is subject to a two-year loss of NATCEP beginning November 28, 2017, as a result of the extended survey that identified the SQC.

On January 12, 2018, MDH surveyors completed an on-site PCR, and on December 28, 2017, the MN Department of Public Safety completed a PCR. They found that the facility had corrected the deficiencies based on its plan of correction as of December 29, 2017.

As result of the revisit findings, we discontinued the Category 1 Remedy of State Monitoring effective December 29, 2017.

In addition, we recommended to your office imposition of the following remedy:

-CMP for the deficiency cited at F-689.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245278

January 25, 2018

Ms. Laura Salonek, Administrator Good Samaritan Society - Howard Lake 413 13th Avenue Howard Lake, MN 55349

Dear Ms. Salonek:

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

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

Effective December 29, 2017 the above facility is recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions related to this electronic notice.

Sincerely,

Anne Retension -

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 25, 2018

Ms. Laura Salonek, Administrator Good Samaritan Society - Howard Lake 413 13th Avenue Howard Lake, MN 55349

RE: Project Number S5278025

Dear Ms. Salonek:

On December 15, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective December 20, 2017. (42 CFR 488.422)

On December 15, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) informed the following enforcement remedy be imposed:

• Civil money penalty for the deficiency cited at F-689. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on December 1, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On January 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 28, 2017 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 an extended survey, completed on December 1, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 29, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on December 1, 2017, as of December 29, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 29, 2017.

However, as we notified you in our letter of December 15, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 1, 2017.

In addition, this Department recommended to the CMS Region V Office that the following enforcement remedy be imposed:

Good Samaritan Society - Howard Lake January 25, 2018 Page 2

• Civil money penalty of for the deficiency cited at F-689. (42 CFR 488.430 through 488.444)

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 electronic notice.

Sincerely, Anne Releason_____ Licensing and Certification Program Minnesota Department of Health

P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 25, 2018

Ms. Laura Salonek, Administrator Good Samaritan Society - Howard Lake 413 13th Avenue Howard Lake, MN 55349

Re: Reinspection Results - Project Number S5278025

Dear Ms. Salonek:

On January 12, 2018, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 1, 2017, with orders received by you on December 18, 2017. At this time these orders were found to be corrected.

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

Please feel free to call me with any questions related to this electronic notice.

Sincerely,

Anne Retenson_

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	DICARE/MEDICAID CERTIFICATION A		ID: L513 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 - HO (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
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 12/01/2017 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 04 SNF 08 OPT/SP 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b):	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12. Total Facility Beds 32 (L18) 13. Total Certified Beds 32 (L17)	1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers:	 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B* 	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SN 32 (L37) (L38) (L39)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLIC See Attached Remarks	ABLE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY A	PPROVAL Date:
Austin Fry, HFE-NE II	12/29/2017 (L19)	Anne Peterson, Enforce	ement Specialist 01/16/2018 (L20)
PART II - TO 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L2)	BE COMPLETED BY HCFA REGIONAL 20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. 1. Statement of Finance	cial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGR OF PARTICIPATION BEGINN 04/01/1985 (L24) (L41)	EEMENT 24. LTC AGREEMENT NG DATE ENDING DATE (L25)	26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTERN A. Suspe	ATIVE SANCTIONS nsion of Admissions: (L44) Suspension Date:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
	(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	00140 (L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APPRO	OVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE &	MEDICAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AND T	RANSMITTAL	ID: L513
PART I - TO BE COMPLETED BY THE STATE SU	RVEY AGENCY	Facility ID: 00019

STATE AGENCY REMARKS

On 11/28/17-12/1/07, an extended survey was completed at this facility. The most serious deficiency, F-689, Free of Accident Hazards/Supervision/Devices, was cited at a scope and severity (S/S) of "J" and was also cited as substandard quality of care (SQC). The immediate jeopardy (IJ) began on 11/28/17 and was removed on 12/1/2017 at 2:19 p.m. But non-compliance remained at an isolated scope and severity that indicated no actual harm with potential for more than minimal harm (Level D). CMS was notified of the IJ on 11/29/2017. The facility has not been cited for a S/S of "G"-or-above deficiency in the last 2 calendar years.

C&T REMARKS - CMS 1539 FORM

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

December 15, 2017

Ms. Laura Salonek, Administrator Good Samaritan Society - Howard Lake 413 13th Avenue Howard Lake, MN 55349

RE: Project Number S5278025

Dear Ms. Salonek:

On December 1, 2017, an extended 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm; Appeal Rights - the facility rights to appeal imposed remedies;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on December 1, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor St. Cloud A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: brenda.fischer@state.mn.us Phone: (320) 223-7338 Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective December 20, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F-689. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Howard Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 1, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an

administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 March 1, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2018 (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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have question related to this letter.

Sincerely,

Anne Retenson_

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· /	E SURVEY IPLETED
		245278	B. WING			12/	01/2017
NAME OF F	PROVIDER OR SUPPLIER	•	•		TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			413 13TH AVENUE IOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	rs	FC	000			
	survey was comple Minnesota Departm determine complian CFR Part 483, subp Term Care Facilities The survey resulted (IJ), substandard qu the facility failed to incidents of cigareth was not comprehen interventions develor safety with unsuper of nursing (DON) a services (DES) wer 11/29/17, and it was p.m. when the facilit plan which included safety with unsuper education to direct burns and injuries, occupational therap determine and impl the resident to smoo In addition, an exte on 12/1/17, for subs The facility's plan o as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	d in an Immediate Jeopardy uality of care, at F689 when ensure a resident with known te burns to clothing and skin nsively reassessed and new oped to provide adequate rvised smoking. The director nd director of environmental re notified of the IJ on s removed on 12/1/17, at 2:19 ity implemented a removal d reassessing the resident for rvised smoking, providing care staff related to reporting and completing an by (OT) evaluation to help lement interventions to allow ske safely unsupervised. nded survey was completed standard quality of care. f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will					
		DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE
Electron	ically Signed						12/22/2017

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: 01/04/2018

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	DIE CONSTRUCTION (X3) I	DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED	
		245278	B. WING		12/01/2017	
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 000	Continued From pa	ge 1	F 00	0		
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility will be conducted to intial compliance with the en attained in accordance with				
	Accuracy of Assess CFR(s): 483.20(g)	sments	F 64	1	12/29/17	
	resident's status. This REQUIREMEN by: Based on interview facility failed to accu Data Set (MDS) for reviewed for urinary Findings include: The Centers for Me Long-Term Care Re Instrument (RAI) 3. 10/2017, identified to be completed with updated, accurate p health status." Furt	ust accurately reflect the NT is not met as evidenced y and document review, the urately code the Minimum 1 of 1 residents (R4) y tract infection(s). edicare and Medicaid (CMS) esident Facility Assessment 0 User's Manual dated "Section I : Active Diagnoses" th an intent of generating, "an picture of the resident's current ther, the manual provided		Preparation and execution of this response and plan of correction does no constitute admission or agreement by th provider of the truth of the facts or alleg or conclusions set forth in the statemen of deficiencies. The plan of correction is prepared and/or executed solely becaus it is required by the provision 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 centers allegation of	ne ed t s	
	any current diagnos "I2300, urinary tract days)." R4's admission MD had intact cognition Diagnoses," of the diagnosis' for R4 w	Puctions directing staff to select sis' including an option of, t infections [UTI] (last 30 DS dated 9/19/17, identified R4 a. Further, "Section I - Active MDS listed several active hich included having I2300 currently or within the last 30		compliance in accordance with section 7305 of the State Operations Manual. F641-Accuracy of Assessments – D lev 1. R4's MDS was modified on Thursday November 30th to reflect her accurate health status and that she did not have UTI.	,	

Facility ID: 00019

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						0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245278	B. WING _		12/0	1/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE		
GOOD S	AMARITAN 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIOI DATE	
F 641	Continued From pa	age 2	F 64	11			
	stated she had a U however, had no re she felt her health R4's progress note had a history of urin however, "does not is continent." R4's medical recorn any evidence R4 had diagnosed with one admission to the fa When interviewed assistant director of completed the MDS urine culture obtain just prior to her adr it was negative for even been started. computer system h answer on the MDS however, again reit	dated 9/21/17, identified R4 mary tract infection (UTI), t have a current diagnosis and d was reviewed and lacked ad a current UTI or had been e in the 30 days prior to		 All current residents who diagnosis of UTI coded on recent MDS will be reviewe MDS is coded accurately, to current health status of UTI MDS coordinator will be re-education by DON or de 12/29/17 regarding active of entered upon admission an section I MDS coding. The DON or designee with MDS Section I audits for Rea other residents to ensure the accurately coded weekly X monthly X 3. Audit results of reviewed by the facility QAR for further recommendation 	the most d to ensure o reflect their l. provided with signee by liagnosis d proper Il conduct 4 and random ney are 4, then will be PI committee		
	code the MDS accu the correct paymen care of the residen A facility Assessme 11/2015, identified assessments are c appropriate regulat individual who com	d adding it was important to urately, "to make sure we get at and [staff are] taking proper t." ent (MDS) policy dated a purpose of ensuring resident ompleted "in compliance with ions," and directed each pletes a portion of the n and certify the accuracy of					

If continuation sheet Page 3 of 33

						FORM	01/04/2018 APPROVED 0938-0391
TATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE SURVEY COMPLETED	
	245278		B. WING	i		12/0)1/2017
NAME OF PROVIDER OR SUPPLIER					2/01/2017		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657 SS=D			F6	657			12/29/17
	§483.21(b)(2) A con- be- (i) Developed within the comprehensive (ii) Prepared by an includes but is not I (A) The attending p (B) A registered nu- resident. (C) A nurse aide wi- resident. (D) A member of for (E) To the extent pr the resident and the An explanation mus- medical record if th and their resident re- not practicable for t resident's care plar (F) Other appropria disciplines as deter or as requested by (iii)Reviewed and re- team after each as- comprehensive and assessments. This REQUIREMED by: Based on interview facility failed to revi- urinary incontinenc was identified with Findings include:	interdisciplinary team, that imited to obysician. rse with responsibility for the th responsibility for the od and nutrition services staff. racticable, the participation of e resident's representative(s). Is the included in a resident's e participation of the resident epresentative is determined the development of the n. the staff or professionals in rmined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the			F657-Care Plan Timing and Revisio level 1. R6's care plan was updated 12/10 reflect resident current health status urinary incontinence. A new bladder assessment was initiated on 12/18/7 will be completed by 12/21/17 and c	8/17 to 5 for 17 and	

Facility ID: 00019

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				3		
		245278	B. WING			01/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	Ξ	
GOOD S	AMARITAN 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 657	Continued From pa	age 4	F 65	7		
	identified R6 was c	ognitively intact and required with toileting. Further, the		plan will be updated as approp	riate.	
MDS identified R urine (less than s R6's care plan da self care perform and limited mobi	MDS identified R6 urine (less than sev	was occasionally incontinent of ven episodes of incontinence).		2. All current residents who had identified per the MDS for black incontinence have been review	der /ed to	
	self care performar and limited mobility indicate she was in	<i>v</i> . The care plan did not continent of urine as identified		ensure that all assessments a care documentation have been per facility policy and procedur	n completed e.	
	assistant (NA)-C st shift and R6's was	n 11/30/17, at 1:35 p.m. nursing ated that she worked the day usually incontinent twice a shift	day for urinary incontinence per GSS police	ely are planning		
	nurse (RN)-A state incontinent of urine identified and addre A facility Comprehe	/30/17, at 1:59 p.m. registered d R6 was occasionally and it should have been essed on her care plan. ensive Care Plan and Care dated 9/17, identified a		4. The DON or designee will c MDS Section H Bowel and Bla continence audits for R6 and r other residents weekly X 4, an monthly X 3 to ensure care pla their urinary continence needs results will be reviewed by QA Committee for further recomm	dder andom d then ins reflect . Audit ⊃l	
F 689	purpose of creating person-centered ca The policy directed reviewed when eac plans "must be revi needs/status chang	g a "holistic and are plan" for each resident. the care plan should be ch MDS is completed and care ised as the resident's ges." azards/Supervision/Devices	F 689			12/29/17
33-J	§483.25(d) Accider The facility must er §483.25(d)(1) The	nts.				

Facility ID: 00019

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION		0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245278	B. WING _			12/0	01/2017	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 689	Continued From pa	ge 5	F 68	89				
	supervision and ass accidents.	sistance devices to prevent						
	This REQUIREMEN	NT is not met as evidenced						
	Based on observat review, the facility f	ion, interview and document ailed to comprehensively lop interventions to provide			F689-Free of Accident Hazards/Supervision/Devices - J le	evel		
	adequate supervision unsupervised smoketing	on and safety with ing for 1 of 1 residents (R8)			1. R8's care plan was updated on 11/29/17 to reflect safety hazards v			
	and skin. This resu	garette burns on their clothing Ilted in an immediate jeopardy andard quality of care, for R8			smoking unsupervised. Smoking sa risk assessment completed on 11/2 Smoking cessation offered and dec	29/17.		
		sk for burns and serious injury			by R8 11/29/17. Care plan was up to include skin checks and inspecti	dated on of		
		/28/17, when it was identified			clothing (for burns) daily at HS fron 11/29/17 thru 12/13/2017. Weekly			
	burns to his clothing	epeated incidents of cigarette g and skin from unsupervised direct care staff had			licensed nurse skin checks thereaf facility policy and procedure. Occup Therapy conducted a smoking safe	oational		
	knowledge of these	was not comprehensively			evaluation on 11/30/17 and 12/1/17 determine if R8 would accept any			
	reassessed and interprovide adequate s	erventions developed to afety with independent,			adaptive smoking equipment to inc safety. Cognitive testing was also	offered.		
	p.m. the director of	ting. On 11/29/17, at 5:06 nursing (DON) and director of			R8 declined any adaptive equipme cognitive testing results showed no			
	IJ for R8. The IJ wa	ices (DES) were notified of the as removed on 12/1/17, at , non-compliance remained at			change in cognition. R8's primary physician provided risks of smoking offered smoking cessation product			
	an isolated scope a actual harm with po	nd severity which indicated no otential for more than minimal			11/30/17, which R8 declined. His E score on 9/13/17 was 15/15 indicat	BIM ing he		
	harm (Level D).				is capable of making these decision			
	Findings include:				2. R8 is the only resident in the fac smokes. Any future residents who	smoke		
	9/13/17, identified F	Im Data Set (MDS) dated R8 had intact cognition, havioral symptoms (i.e.			that elect to be admitted despite the center's non-smoking policy will be assessed for smoking safety, and			
	yelling, cursing) and	havioral symptoms (i.e. d did not display any episodes R8's medical diagnoses			assessed for smoking safety, and p centered approaches will be impler			

Facility ID: 00019

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED	
		245278	B. WING	· · · · · · · · · · · · · · · · · · ·		01/2017	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
	AMARITAN SOCIETY			413 13TH AVENUE			
GOOD 3				HOWARD LAKE, MN 55349			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 689	included quadripleg and muscle weakmextensive assistance (ADLs), total assist and currently used displayed no skin to degree) or other op Further, R8's Media 11/29/17, identified spasms and contra (shortening or hard or other tissues offer rigidity of a joint) to R8's last completed dated 9/14/16, iden tobacco and smoke all hours (i.e. morn desire to quit. R8 v regarding daily life demonstrated no v did have dexterity of his/her ability to sm according to the as did not identify what concerns were, not would be addresse limitations which we to get outside or bat assessment listed a which identified R8	gia (paralysis of all four limbs) ess. Further, R8 required ce with activities of daily living ance from staff for transfers, tobacco products, however, ears, burns (2nd or 3rd ben lesions on his skin. cal Diagnosis listing printed R8 had a history of muscle acture of the muscle(s) ening of the muscles, tendons en leading to deformity or an unspecified site. d Tobacco Use Assessment tified R8 currently used ed over 10 times a day during ing, afternoon, night) with no was able to make decisions independently and ision impairment(s), however, concerns which, "would affect toke or use tobacco products" sessment. The assessment at R8's identified dexterity any information on how they d. R8 displayed no physical ould interfere with their ability tok in the center. The a section labeled, "Safety," was able to light his own	F 689		/30/17 and til all staff were of education ACT stop and ommunicating ents; and injuries f will notify anges found in for R8 and any ly X 4, then checks are appropriately. larterly X 3, to ssessment is appropriately. ed by the QAPI		
	to get outside or ba assessment listed a which identified R8 cigarette and conta need for adaptive e choices to select in cigarette holder, su assistance. The op was checked. Furt	t outside or back in the center. The ssment listed a section labeled, "Safety," in identified R8 was able to light his own ette and contained a question of, "Resident for adaptive equipment," along with several ses to select including a smoking apron, ette holder, supervision, one to one tance. The option for, "None of the above," checked. Further, the assessment identified ad no history or incidents with dropping the ette, falling asleep while smoking, burning					

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PRINTED: 01/04/2018

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/04/2018 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245278	B. WING			12/	01/2017		
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 689	himself or clothing, tobacco-related bel assessment lacked location for R8's sm cigarette or ash dur attempted intervent or unsuccessful for R8's care plan print bilateral hand contr injury along with lim to quadriplegia. R8 without staff assista device, and demon- concerns along with towards staff." Furt R8 used tobacco pr listed a goal of, "[R8 products in designa burns." The only in this goal was identif tobacco use, cigare on my wheelchair a plan lacked any furt past offered or refu R8's unsupervised On 11/28/17, at 1:5 smoke. R8 wheele electric wheelchair hallway. R8 had vis fingers on both han himself past the rec of the facility and di facility prior to exitir down to the end of remained on the nur removed an opened	or other unacceptable navior(s) in the past. The any information on physical noking, his ability to hold a ing use, or any history of ions which had been refused R8. ed 11/29/17, identified R8 had actures due to a spinal cord lited physical mobility related was unable to transfer ance and a mechanical lift strated potential mood n notation he, "easily angers ther, the care plan identified roducts off facility grounds and B] will safely use tobacco ited area. I will be free from tervention listed to help meet fied as, "I am independent with ettes and lighter are in a pouch nd always with me." The care ther information, including any sed interventions, pertaining to	F6	89					

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	OF DEFICIENCIES		(Y2) MILLT	IPLE CONSTRUCTION				
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG		TE SURVEY MPLETED		
		245278	B. WING _		12	2/01/2017		
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE			
GOOD SA	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 689	Continued From pa	ige 8	F 68	39				
		e down on his lap exposing a						
	and metal sparkwh	ard lighter with a plastic body eel.						
	R8 picked up the cigarette using his thumb and pointer finger and placed it into his mouth, the rest of his fingers being contacted inwards towards his palm(s). R8 attempted several times to light the cigarette in his mouth using the lighter, however, was unable to after several attempts. R8 stated he had, "lots of years practice," lighting his cigarettes in the wind and removed it from his							
his c mou ciga rema towa	his cigarettes in the mouth. R8 then us cigarette with his th remaining fingers w towards the palm.							
	abdomen with both several times with v being held immedia he attempted to ligh	hands while flicking the lighter visible sparks and open flame ately next to his sweatshirt as ht the cigarette and bring it to be cigarette and used his right						
	going outside on his hour and a half or s himself before while	es several times a day often s own to smoke, "once every so." R8 stated he has burned e smoking as ash or the ed hot ash on the end of the lit						
	cigarette]" will fall o his skin due to poor downward. R8 stat	ff and he is unable to feel it on r sensation from his shoulders ted he last burned himself a and showed the surveyor a						
	surrounded by light aspect of his first fir	colored scabbed area pink colored skin on the inner nger of his right hand. The ately 0.5 centimeters (cm) in						

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		AND HUMAN SERVICES				FORM	01/04/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245278	B. WING			12/	01/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			13 13TH AVENUE OWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	R8 then lifted up his showed a visible, a diameter, hole in th the sweatshirt. R8 ash which had falle R8 stated none of t about his smoking ap "heck no." R8 state complication or pote fire, he would use h nursing home and a smoking his cigared from his mouth usin the remaining filter did not extinguish th of it. R8's most recently V2 dated 11/21/17, pressure ulcer on h lacked any identifie right hand. When interviewed of nursing assistant (N smoke after he gets typically "gone a few stated she had new outside to observe had noticed burn ho The most recent bu jacket, however, N/ these were old or n owned the coat for R8 was independer	age 9 s gray colored sweatshirt and pproximately 2.5 cm in le center of the front side of stated it was from a cigarette on on it from awhile prior. The staff had spoken to him nor do they come outside with es, however, when questioned bron being used he replied, ed if he were to have a entially start his clothing on his cell phone to call the ask for help. R8 finished tte at 2:08 p.m. and removed it ng his right hand and tossed and butt into the street. R8 he cigarette before disposing completed Skin Observation - identified R8 had a chronic his gluteal fold(s), however ed burns or skin injuries on his on 11/28/17, at 2:24 p.m. NA)-A stated R8 goes out to s up for the day and then is w hours" around town. NA-A er personally helped or gone R8 while smoking, however, oles in his clothing before. un holes being on his winter A-A stated she was not sure if new burn holes though as he awhile. Further, NA-A stated nt with his smoking and staff or did R8 wear or use any	F 6	89			

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). 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED	
		245278	B. WING		12	/01/2017	
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 689	•	age 10 hile smoking to her	F 689)			
	stated R8 smoked "not supposed to," wanted to smoke w they had to be able assistance becaus NA-B stated she ha burns on his hands hot and creates a b "every couple mon observed a burn or three months prior motion on his hand always notice them had reported these however, was unab had been reported the surveyor and N to observe his burr check for additional left the facility and During interview or assistant (LA)-A sta	n 11/29/17, at 8:49 a.m. laundry ated she completed all					
	personal laundry for smoked adding his functional." LA-A s burn holes in his cl she doesn't "look a turned and remove which had been ha room. R8 had a pl several holes in the these were "wear h	or R8 and was aware he hands "aren't 100 percent tated she had never noticed othing before, however, added t them that close." LA-A ed several pieces of clothing nging on a rack in the laundry ain green colored shirt with the front. LA-A stated she felt noles" though. LA-A removed weatshirt R8 had worn the day					

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		& MEDICAID SERVICES			OMB NO	MAPPROVE 0. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION		TE SURVEY MPLETED		
		245278	B. WING _		12	2/01/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349				
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 689	and inspected it. L of the sweatshirt ar a cigarette burn." If currently was not in completing his laur should be checking When interviewed of trained medication smoker and goes " property" to smoke TMA-A stated R8 w and was able to sa lighter without assis of any burns on R8 stated staff should charge nurse and c (an 'early warning t identified while car stated she "would a the cigarette and/or was smoking as R8 himself when smok out using a paper lo smoke. TMA-A show which identified sev failed to sign himse he returned. TMA- stated R8 "should the record as "he's bee TMA-A stated staff he returned from su around town. An undated, blank Warning Tool" was instructions to com identified a change	age 11 A-A verified a hole in the front hd stated, "I would say that was Further, LA-A stated she hspecting R8's clothing when hdry, however, added "I guess I g [his] clothes better." on 11/29/17, at 9:33 a.m. aide (TMA)-A stated R8 was a down to the end of the after he gets up for the day. vas independent with smoking fely use cigarettes and a stance. TMA-A was unaware 's skin or clothing, however, "report it right away" to the complete an Stop-and-Watch ool' used when a change is ing for a resident). TMA-A assume" R8 would just put out r fire, if one occurred, while he 8 took "full responsibility" for king. R8 was to check in and og when going outside to owed this log to the surveyor veral empty spaces when R8 elf back into the facility when A reviewed the record and be" filling out the sign in/out en told to" use it. Further, did not inspect R8's skin when moking or from his outings "Stop and Watch Early provided. The form listed plete one when, "you have while caring for or observing a rovide the form to a nurse for	F 6	89				

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		AND HUMAN SERVICES				FORM	01/04/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245278	B. WING			12/	01/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	follow-up. Some ex to be watchful for in usual," and, "Chang R8's medical record these had been cor skin or clothing. R8's medical record progress note date smoke and did not time further adding risk/benefit of all ed makes." The note what information re been provided, nor were discussed and unsupervised smok An electronic progra identified R8 "contin cigarettes independ lighter at all times." observation, assess how this determinat unsupervised smok R8's physician prog through 11/21/17 (n reviewed and identified period. R8 was ide on each of the visits identified as having remain on Valium (n anxiety and muscle spasms". All of the	xamples provided on the form noluded, "Seems different than ge in skin color or condition." d lacked any evidence one of mpleted for any burns in his d was reviewed. A handwritten d 4/16/13, identified R8 to want to pursue quitting at the him to, "understands ducation and choices that he lacked any information on elated to safe smoking had what interventions, if any, d/or refused to ensure safe king. ess note dated 6/21/17, nues to be safe to smoke his dently and hold them and the The note lacked any sment or dictation to describe tion had been made of R8's king abilities. gress note(s) dated 2/14/17, nost recent visit), were ified R8 had been seen by his seven times in the 10 month entified as a "current smoker" s. On 2/14/17, R8 was g quadriplegia and needed to medication used to treat e spasms) "for control of e provided notes lacked any smoking related injuries or his	Fé	589			

Facility ID: 00019

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED	
		245278	B. WING _		12	2/01/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349				
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 689	Further, the medica reassessment of R abilities despite ob- skin described by N occupational theral smoking; nor evide interventions to pro- smoking. In addition, the rec- recorded incident r burns sustained or described by NA-A the facility had atte collaboration with F interventions or the unsupervised smol additional notes or regarding these ite During interview or stated she was aw was the "first thing gets up." R8 was i and when he leave for himself then." I been told of any bu before; nor had she smoking apron bef a nice thing to have report incidents, lik burning himself, to When interviewed NA-F stated staff " smoking. R8 goes	al record lacked any identified 88's unsupervised smoking taining burns on clothing and NA-A and NA-B; any history of py (OT) interventions for his ence of other attempted bornote safety with unsupervised ord lacked any documented or eport(s) related to the cigarette his clothing and skin as and NA-B, nor any evidence mpted to provide on-going 88 to develop and implement erapies related to his king. The facility provided no medical record entries ms during the survey. 11/29/17, at 12:47 p.m. NA-E are R8 smoked and added it he does when he goes and ndependent with his smoking us to smoke, he "is responsible NA-E had never noticed or urns on R8's skin or clothing e ever seen him wear a fore, however, felt it would "be e" as R8 was not someone to e dropping the cigarette or	F 68	39			

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY		
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	CO	MPLETED		
		245278	B. WING		12	2/01/2017		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE		
F 689	Continued From pa	age 14	F 6	89				
		ns upon his return, but merely as it?"						
	asking him "how was it?" On 11/29/17, at 1:03 p.m. registered nurse (RN)-C was interviewed and identified R8 was a quadriplegic, had poor sensation and contracted fingers on both hands and was supposed to sign himself out of the building each time he wanted to smoke as he was unable to smoke on facility grounds. RN-C was unaware of any burns on R8's clothing or skin resulted from cigarette smoking as "nothing got reported." RN-C stated if staff are noticing burns on his clothing and skin, it should be reported to the nurses immediately so the physician can be updated and an incident report can be completed. Further, RN-C stated R8 was independent with using his cigarettes and lighter, however, added she had never watched him smoke personally nor was she aware how he had been assessed to be safe with smoking before the survey.							
	stated she had wor approximately two a smoked "since he o years prior. R8 typ and then "does his as he is unable to s grounds, however, just go down to the smoke in the later of	11/29/17, at 1:27 p.m. RN-B ked at the facility for and a half years and R8 had came" to the nursing home ically gets assisted out of bed own thing in the community" smoke on the campus RN-B added at times R8 will end of the driveway and evening hours. RN-B stated on a smoking assessment had						
	been done on adm not sure adding she safe unsupervised she was unaware F cigarette burns on	e" a smoking assessment had ission for R8, however, was e had never assessed him with smoking before. RN-B stated R8 had been sustaining his clothing and skin as it had to her or raised as a concern						

Facility ID: 00019

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		AND HUMAN SERVICES				FORM	01/04/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245278	B. WING			12/	01/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			413 13TH AVENUE IOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	until now. RN-B sta ever been consulter R8's unsupervised I've been here." Fut himself while smoke should do somethin "we got to be keepi When interviewed of stated she was away however, added she location(s) he was se don't feel like I'm hit person" when he le was unaware R8 ha his hand, nor was se being observed in h with R8's paralysis contributed that he, burning his skin or staff should be reports so it could be addres safety." On 11/29/17, at 2:1. nursing (ADON) was she had worked at four years and R8 h time. R8 was last a smoking in Septerm 9/14/16), and she fe ADON stated R8 "ut everything" includin however, she was ut cigarette in 2016 with ADON stated she w burning his clothes adding the NA staff	ated she did not think OT had d in the past to help address smoking adding, "not since urther, RN-B stated R8 burning ing made her "feel like I ng right now" to help him as ng him safe." on 11/29/17, at 1:55 p.m. RN-D are R8 goes outside to smoke, e did not know the physical smoking when outside as, "I s babysitter." R8 was "his ft the facility. RN-D stated she ad a current cigarette burn on she aware he had burn holes nis clothing by staff. RN-D felt	F	\$89			

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		AND HUMAN SERVICES				FORM	01/04/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED	
		245278	B. WING			12/	01/2017	
NAME OF	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	concern with a resid clothing and/or on t tool should have be addressed and R8 safety with smoking was unaware if any burns with R8, nor t to help develop inter safe with his unsup A provided UDA (us Reference Guide da which identified it haprior to survey. The assessments along when to complete the Assessment was lis completed by a reg " on admission for products; required the use tobacco product completed; or when ability, judgment, m mobility." Further, the assessment should "incident" occurred an injury type. During interview on stated she was new unaware of the faci regarding having a completed. OT-A re and stated there was consulted for R8 for however, OT-A state compensatory mether R8 did not have use	dent, like cigarette burns in heir skin, a stop-and-watch een completed so it could be could be reassessed for his g. Further, ADON stated she rone had discussed the risk of had OT ever been consulted erventions to ensure R8 was	Fé	\$89				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION						OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 245278				ING		(X3) DATE SURVEY COMPLETED		
		B. WING			12/01/2017			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE			
GOOD S	AMARITAN 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	DN SHOULD BE COMPLETI IE APPROPRIATE DATE			
F 689	• · · · · · · · · · · · · · · · · · · ·	-	F 6	89				
	cognition, looking a skills while using a comprehensive ass sensation and OT- even know he's beis stated if someone of sensation was sust unsupervised smot appropriate to revise functional deficits a On 11/29/17, at 2:4 (DON) was intervie unsupervised smot working at the nurs her knowledge R8 interventions from a "his own person an well pleases," and things, then being of day and yelling at the interventions offeres smoking were done and they just had n stated she was una himself while smok reported, however, burns in his clothing have completed a could be treated an Further, DON state	including assessing his it his dexterity and handling cigarette and "just do a sessment." R8 had impaired A questioned, "Does he [R8] ing burned?" Further, OT-A with impaired dexterity and taining cigarette burns with king, it would be OT ew them so as to "assess and safety." 5 p.m. the director of nursing wed regarding R8's king. DON stated she started ing home in June 2017, and to had always refused staff for his smoking. R8 was d will do whatever he dang had a history of telling the staff upset about them the following hem. DON stated the ed to him in the past with his e as in passing conversations ot been documented. DON aware R8 had been burning ing as it had not been if NA staff noticed cigarette g or on his skin, they should Stop-and-Watch so the burns ad staff "can be looking at it." d the facility was ultimately ure R8 was safe, however,						
	own person. Durin 11/29/17, at 5:06 p. made to the State a potential neglect fo	self out and leaves, he was his g a follow up interview on .m. DON stated a report was agency (SA) regarding r R8 since he had been burns from unsupervised						

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		245278	B. WING			12/(01/2017			
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>				
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			413 13TH AVENUE					
	D SAMARITAN SOCIETY - HOWARD LAKE			HOWARD LAKE, MN 55349						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	CTIVE ACTION SHOULD BE COMPLE ICED TO THE APPROPRIATE DATE				
F 689	Continued From page 18 smoking.		F 6	89						
	A facility Smoke-Fre 3/2016, identified it smoking inside Goo buildings was not p "All residents/clients products will be ass listed which directed designate acceptab resident smoking w for staff member ob residents who use t Use Assessment co assessments would has a change in coo dexterity or mobility direction or procedu how to address ciga and/or skin, should A Smoking and Tob identified it applied purpose of reaffirm safe and healthy en residents and visito smoking shall be do entrance of the faci "readily visible" to s smoke must not po themselves or other direction or procedu how to address safe burn(s) on clothing occur.	ee Locations policy dated applied to skilled care and od Samaritan Society (GSS) ermitted. The policy directed, s who smoke or use tobacco sessed." A procedure was d staff members would ole outdoor locations for which "must be readily visible oservation." Upon admission, tobacco will have a Tobacco ompleted. Further, additional d be completed if a resident gnition, judgment, manual where for staff to implement on arette burn(s) on clothing they occur. bacco Use policy dated 4/2017, to skilled care and listed a ing the GSS commitment to "a nvironment for employees, ors." The policy directed one away from the main ility in spaces which were staff. Further, "Residents who se a safety hazard to rs." The policy lacked any ure for staff to implement on ety with smoking nor cigarette and/or skin, should they								

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PRINTED: 01/04/2018

	-	AND HUMAN SERVICES			FORM	01/04/2018 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED		
		245278	B. WING		12/	01/2017		
NAME OF F	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	(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 689	Continued From pa	ige 19	F 689					
	12/1/17, at 2:19 p.n implemented a rem following:	n on 11/28/17, was removed on n. after the facility successfully loval plan which included the						
	smoking which ider apron, cigarette hol one assistance. R& interventions, howe evaluation for safet identified R8 to now related incidents ind incident of burning report as it was "no progress note for R dated 11/29/17, at 6 ADON. ADON exp the burn(s) for pote demonstrated how as reporting he had observed by the sur have gotten a differ	ed by nursing for unsupervised htified he required a smoking lder, supervision and one on 8 refused all of these ever, R8 "agreed to [OT y]." Further, the assessment v have a history of smoking cluding "a self reported his finger" which he failed to t a big deal." A subsequent 8's smoking reassessment 6:45 p.m. was authored by lained to R8 they had reported ential neglect of care while R8 he smoked. R8 was identified I a "shitty lighter" when rveyor on 11/28/17, and should rent one, "instead of fighting and almost burning my shirt."						
	- An OT consultatio assess and develop unsupervised smok Treatment Note dat having an "incomple C5 - C7 [vertebrae] sensation, impaired impaired motor con evaluation which ide the lighter away from thumb still very near	on was made for R8 to screen, o interventions for safe, king. A provided OT Daily ted 12/1/17, identified R8 as ete SCI [spinal cord injury] at ," who had impaired d upper body strength and ttrol. OT completed a smoking entified R8 was able to strike m his body, however, "[his] ar flame when lighting. Will lore options to reduce risk of						

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245278		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		B. WING		12/01/2017		
	PROVIDER OR SUPPLIER	- HOWARD LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 689	plastic-smoking ad with throwing out th hot end nears hand - Educating all staff on clothing and/or s and documented. On 12/1/17, from 2 and direct care staft training had been p unsupervised smok skin and clothing w potential burn injuri tool and communic conditions timely, a pertaining to a char Bowel/Bladder Inco CFR(s): 483.25(e)(§483.25(e) Incontir §483.25(e)(1) The resident who is con admission receives maintain continenc condition is or becc not possible to mai §483.25(e)(2)For a incontinence, base comprehensive ass ensure that- (i) A resident who e indwelling catheter resident's clinical c catheterization was	aptor and e-cigarettes, along ne cigarette mid-way "before d." f on ensuring cigarette burn(s) skin were immediately reported :01 p.m. to 2:18 p.m. nursing ff were interviewed to ensure provided related to R8's king including ensuring R8's ras routinely monitored for les, use of the Stop-and-Watch ating changes in resident and documentation standards nge in condition. Datinence, Catheter, UTI 1)-(3) nence. facility must ensure that thinent of bladder and bowel on a services and assistance to e unless his or her clinical omes such that continence is ntain. resident with urinary d on the resident's sessment, the facility must enters the facility without an is not catheterized unless the ondition demonstrates that	F 689			12/29/17

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	OMB NO.	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` ´	G		PLETED	
		245278	B. WING _		12/	01/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 690	• · · · · · · · · · · · · · · · · · · ·	ge 21 noval of the catheter as soon	F 69	0			
	as possible unless demonstrates that of and (iii) A resident who receives appropriat	the resident's clinical condition catheterization is necessary; is incontinent of bladder e treatment and services to ct infections and to restore					
	ensure that a reside receives appropriat restore as much no possible.						
	review the facility fa	tion, interview and document ailed to comprehensively idents (R6) with a change in		F690-Bowel/Bladder Incontinent Catheter, UTI - D level 1. R6's care plan was updated 1	2/18/17 to		
	Findings include:			reflect resident current health sta urinary incontinence. A new blad assessment was initiated on 12/	der I8/17 and		
	6/21/17, indicated s hypertension and d	num Data Set (MDS) dated she was cognitively intact, had iabetes mellitus. The MDS		will be completed by 12/21/17 ar plan will be updated as appropria	ite.		
	urine and was not of quarterly MDS date now occasionally in on a toileting progra assessment (CAA)	dated 3/29/17, indicated she		2. All current residents who have identified per the MDS for bladde incontinence have been reviewe ensure that all assessments and care documentation have been of per facility policy and procedure.	er d to plan of		
	toileting. The CAA diuretics and did no	y and need for assist with indicated she received ot indicate she was incontinent. ed 9/28/17, indicated she had		3. The DON or designee will pro- re-education on comprehensively assessing/re-assessing and care for urinary incontinence per GSS	/ planning		

Facility ID: 00019

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		AND HUMAN SERVICES				FORM	01/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION		E SURVEY IPLETED
		245278	B. WING			12/	01/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			13 13TH AVENUE IOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 690	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F6	90	and procedure. 4. The DON or designee will cond MDS Section H Bowel and Bladder continence audits for R6 and rand other residents weekly X 4, and the monthly X 3 to ensure care plans their urinary continence needs. A results will be reviewed by QAPI Committee for further recommend	er om en reflect .udit	
	worked the day shift incontinent twice a On 11/30/17, at 1:5 (RN)-A stated R6 d assessment after h urine to occasional	 5 p.m. CNA-C stated that she ft and R6 was usually shift when she worked. 9 p.m. Registered Nurse id not receive a bladder er change from continent of y incontinent of urine. RN-A as aware this was an area 					

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		& MEDICAID SERVICES	0.00). 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		245278	B. WING		12	/01/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 690	they needed to wor performance impro- they wanted more r urine. RN-A further program assessme for quarterly bladde missed. In addition able to print a histo 30 days based on r documentation. During interview 12 stated that when sh usually continent of Although R6 had a the facility failed to minimize the risk of A facility policy Blac 3/17, indicated the bladder patterns, in identify potentially r incontinence and to urinary incontinence programs. The Ass be done quarterly a should be individua modified as approp assessment/evaluat to the interventions	k on and it was part of their vement project. RN-A stated residents to be continent of r stated currently the computer ent tool did not provide an alert er assessments so they were n RN-A stated they were only ry of incontinence going back nursing assistant 2/1/17, at 8:03 a.m. CNA-D ne worked with R6 she was f urine. change in urinary incontinence reassess the incontinence to f further change. dder Assessment revised purpose is to review/assess icontinence and frequency, to eversible causes of b identify the probable type of e and potential toileting sessment indicated this should ind care plan interventions lized based on the CAA and riate based on tion of the residents response and success with ng bladder continence.	F			12/20/17	
	CFR(s): 483.80(a)(§483.80 Infection C The facility must es	1)(2)(4)(e)(f)	Fδ	υ		12/29/17	

If continuation sheet Page 24 of 33

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI F	CONSTRUCTION		0. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	• •				MPLETED
		245278	B. WING			12	/01/2017
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		41 HC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	_D BE	(X5) COMPLETIO DATE
F 880	Continued From pa	age 24	F 8	80			
	comfortable enviro	e a safe, sanitary and nment and to help prevent the ransmission of communicable tions.					
	program. The facility must es	n prevention and control stablish an infection prevention m (IPCP) that must include, at lowing elements:					
	reporting, investiga and communicable staff, volunteers, vi providing services arrangement base	stem for preventing, identifying, ating, and controlling infections diseases for all residents, sistors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards;					
	procedures for the but are not limited (i) A system of surv possible communic infections before th persons in the facil	veillance designed to identify cable diseases or ney can spread to other					
	communicable dise reported; (iii) Standard and to to be followed to pr (iv)When and how resident; including (A) The type and d	ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a					

		AND HUMAN SERVICES			FORM): 01/04/2018 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	TIPLE CONSTRUCTION	0.01	TE SURVEY MPLETED
		245278	B. WING	i	12	/01/2017
	PROVIDER OR SUPPLIER	- HOWARD LAKE	•	STREET ADDRESS, C 413 13TH AVENUE HOWARD LAKE,	CITY, STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	circumstances. (v) The circumstances must prohibit emploid disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in §483.80(a)(4) A system of the corrective actions the corrective actions the staff state of the corrective actions the staff state of the corrective actions the state of the facility will contact will contact the facility will contact for the facility will contact for the facility factor of the facility factor of the facility. Findings include: The facility's infecting from June 2017, the facility provided for the facility factor of the facility factor of the facility factor of the facility.	sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct nts or their food, if direct t the disease; and he procedures to be followed direct resident contact. stem for recording incidents facility's IPCP and the aken by the facility. ndle, store, process, and as to prevent the spread of review. duct an annual review of its heir program, as necessary. NT is not met as evidenced tion, interview and record		 level 1.&2. All reside affected. All reducted. All reductions in the requiring immediate and the activity for identifying infections. All the attending Infection track 	on Prevention and Control - F lents had the potential to be residents were reviewed to here were any infections lediate action. None were has implemented a system and documenting all l infections will be noted by nurse on the GSS 157 king tool as they occur. The ses will notify the Infection	

Facility ID: 00019

						0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED		
		245278	B. WING		12/	01/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE			
good s	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE		
F 880	line present for month and year. The headings on top of the graph identified the total number of infections, the number [of infections] center acquired (nosocomial), and the number		F 880	Control nurse when notin like infections. The Infect nurse will utilize the GSS to conduct monthly trendi	tion Control 157 tracking tool			
	community acquire included the followi number, date admi infection, culture ta agent, antibiotic tre isolation (yes or no no). This documen designations for sy	d. The columns on the logs ng information: name, room tted, date of infection, site of ken (yes or no), causative atment, cautionary measure,), and center acquired (yes or it did not have any mptoms not treated with acterial infections such as viral		 These results will be revie QAPI committee monthly will be developed as appr nursing staff will be provid this process by the DON 4. Audits will be conducted Control nurse to ensure the tracking tool is being combasis when a new infection 	ewed by the and action plans opriate. All ded education on by 12/29/17. d by Infection he GSS Infection opleted on a daily on is identified.			
	Review Report, as titled monthly infect summary included types, and identified nosocomial or com	ovided documents titled Data well as a summary document tion control report. The a breakdown of infection d whether the infection was munity acquired. Hand written m of the form were titled on Plan".		These audits will be done then monthly X 3. Audit r reviewed by the QAPI cor further recommendations	esults will be nmittee for			
		ogs identified the following:						
	Infections in Center six residents were to total of 10 courses categories of infect infections as follow three residents; gas difficile - c. diff. a hi which may cause do respiratory/lung infe	d Monthly Report of Resident r, dated June of 2017 identified treated with antibiotics for a of antibiotic therapy. The ion included the breakdown of s: Prophylactic antibiotic use - strointestinal (clostridium ghly infectious bacterial illness iarrhea) - one resident; ections - three residents; skin idents; and a urinary infection						

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245278	B. WING _		12	2/01/2017
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 880	who had received a antiviral's in the mo antifungal's and an report, only those re- were listed on the r Monthly Infection C of one nosocomial acquired infections infections, yet six re- the document. A h titled Trends, identific continued infection 2017), and identifier reflect a "Downwar not included to ider pattern identified. T education on aspira copy learning as we and skin/soft tissue requested, a Data I provided for 6/17. The Monthly Report four residents were	age 27 antibiotics, antifungal's, onth of June. Although tiviral's were noted on the esidents receiving antibiotics eport of infections. The control Report identified a total infection and four community , to total five identified esidents were addressed on and written narrative note, fied the presence of one from the previous month (May ed the number of infections d trend". Additional data was ntify the previous trends or any the action plan identified staff ation pneumonia with hard ell as urinary tract infections, e education. Although Review Report was not	F 88	80		
	respiratory/lung infe infections - one response resident. The M Report identified a infection, and two of A hand written narr identified a resolve admission, with ide However, the reside antibiotic use. One skin/soft tissue hea initial log reflected in	ion included the following: ections - three residents; skin ident; and a urinary infection in Monthly Infection Control total of one nosocomial community acquired infections. ative note titled Trends, d urinary tract infection upon ntified negative lab work. ent continued on prophylactic incident was identified as ling without antibiotics. The intravenous antibiotics were eatment. The action plan				

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CO	MPLETED
		245278	B. WING			2/01/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 880	identified staff educ infection prevention July. A Data Review month of 7/17. The one resident was tr tract infection, whice infection remained document additional discontinue antibiot prophylactic antibiot the review identified positive, it did not p previous trends, no data measure, the The document indic reviewed by the QA Performance Impro- and no action was The report dated Au residents were treat of three courses of resident was noted categories: respirate infection, and gastr Order Listing Repo- there was one reside antibiotic therapy the individuals being tree powder. An Order identified one additt antibiotic therapy, a receive antifungal t Infection Control Re- nosocomial infection.	cation on handwashing and n provided at a staff meeting in w Report was provided for the positive findings identified eated for an upper respiratory h was nosocomial. The isolated to one resident. The ally noted attempts to tic therapy for a resident on a tic were successful. Although d the data trending was rovide a comparison to r did it identify a goal for the goal was "to be determined". cated the information had been API (Quality Assurance ovement) group on 8/25/17,	F 88	30		

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TATEMENT	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION		OMB NO	TE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		NG			MPLETED	
		245278	B. WING			12	/01/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, C	CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORREC RRECTIVE ACTION SHO ERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 880	Continued From pa	-	F 8	80				
	identified staff re-ed	nfection. The action plan ducation on isolation						
	diff. A Data Review	to recurrent problems with c. v Report was provided for the positive findings identified one						
	resident was treate	d for upper respiratory tract nosocomial, which remained						
	isolated to one resi	dent. The negative findings tic antibiotic treatment with risk						
	resident with c. diff	ement noted. It was also noted positive culture will always test						
	positive, but no con	eview identified trending was nparisons were provided. The						
	yet "to be determine	continued to indicate it was ed". Although the review						
	provide a comparis	rending was positive, it did not on to previous trends, nor did						
	information was no	the data measure. The ted to have been reviewed by 9/20/17 with no action taken.						
	identified seven res	t for September of 2017 sidents were treated with						
	therapy. Upon revie	al of eight courses of antibiotic ew of the entries, it was noted 8/26/17. The categories of						
	follows: skin infection	he breakdown of infections as ons - two residents, urinary						
	resident. An order	idents, and c. diff. in one listing report, dated 10/18/17, ose receiving antibiotic and						
	antifungal therapy. Report identified a	The Monthly Infection Control total of three nosocomial						
	infections. A hand w	community acquired written narrative note, titled						
		o trends were noted. A nade identifying the c. diff.						

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	ì í	NG		MPLETED		
		245278	B. WING		12	2/01/2017		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE		
F 880	Continued From pa	ige 30	F 8	80				
	acquired, one was "procommunity adm a "situation, backgr recommendation (S provided to physicial interventions implet monitor hand hygie this would be done, requested but not p The October 2017, the center identified courses of antibiotic infection included th follows: respiratory, gastrointestinal/cold listing report, dated those receiving ant The Monthly Infecti total of two nosocol community acquire narrative note, titled were noted. The ac [influenza]/pneumo noting reeducation precautions/vaccina was provided for th noted a positive dat the facility goal was information was no the QAPI team on taken. The November 201 in the center identiff name and first initia additional documer	nosocomial, and one was nit." The action plan identified ound, assessment, SBAR)" notification was ans, staff educated and mented. A note was written to ne, however, it did identify how . A Data Review Report was provided for the month of 9/17. report of resident infections in d three residents with four c therapy. The categories of he breakdown of infections as /lung - two residents, and on - two residents. An order 11/13/17, was provided for ibiotic and antifungal therapy. on Control Report identified a mial infections, and one d infections. A hand written d Trends, identified "flu nia season approaching,						

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						<u>). 0938-039</u> TE SUBVEY		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED		
		245278	B. WING		12	2/01/2017		
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349				
(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 COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE		
F 880	11/27/17. There we provided when the was initially reviewe requested, the Mor and Data Review re 11/17. During the interview director of nursing regarding infections admitting to the fac received. The DON was monitored thro the information on compiled monthly. regarding current in Communication Bo the DON further sta to day as it was use trending. In reviewi the DON stated sta provided for handwi identified an increa tract infections in 9 monitored for ongo through observation UTI's was identified demonstrations of 1 implemented. The was compared to the there was no docur table titled Residen dated 2017 was pro- January thorough J	/17/17, 11/17/17, and ere no additional documents Infection Control Log book ed 11/28/17. Although htthly Infection Control Report eport was not provided for w on 12/1/17, at 9:43 a.m. the (DON) stated the information s was obtained on residents sility, with lab results recorded if I stated tracking and trending bugh QAPI. The DON stated the infection control log is Staff relayed information	F 8	80				
	A facility policy, title	ed Surveillance, reviewed						

Facility ID: 00019

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		AND HUMAN SERVICES					FORM	01/04/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION			E SURVEY PLETED
		245278	B. WING	;			12/0	01/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			413 13TH AVENUE HOWARD LAKE, MN 55349			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 880	10/17 identified sur analyze, control and infections." The de process as date co establishment of tr	veillance as an activity to "find, d prevent nosocomial finition further outlined the llection, analysis of data, ends, passing the information ed to take action and	F	880				

Facility ID: 00019

If continuation sheet Page 33 of 33

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	I.				0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY PLETED
		245278	B. WING			12/	01/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			I13 13TH AVENUE IOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
	Emergency Prepare	iance with CMS Appendix Z edness Requirements, was /, through 12/1/17, during a /y.					
F 000	The facility was in f deficiencies are iss INITIAL COMMENT		FC	000			
	survey was comple Minnesota Departm determine compliar	gh 12/1/17, a recertification ted by surveyors from the nent of Health (MDH) to nee with the regulations at 42 part B, requirements for Long s.					
	(IJ), substandard qu the facility failed to incidents of cigarett was not comprehen interventions develous safety with unsuper of nursing (DON) at services (DES) wer 11/29/17, and it was p.m. when the facili plan which included safety with unsuper education to direct burns and injuries, occupational therap determine and impl the resident to smo	d in an Immediate Jeopardy uality of care, at F689 when ensure a resident with known the burns to clothing and skin hsively reassessed and new oped to provide adequate vised smoking. The director and director of environmental e notified of the IJ on a removed on 12/1/17, at 2:19 ty implemented a removal d reassessing the resident for vised smoking, providing care staff related to reporting and completing an by (OT) evaluation to help ement interventions to allow ke safely unsupervised.					
LABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	ically Signed						12/22/2017

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: 01/18/2018

		AND HUMAN SERVICES			FORM	01/18/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245278	B. WING		12/	01/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 000	Continued From pa	ige 1	F 0	00		
F 641 SS=D	as your allegation of Department's accelenrolled in ePOC, y at the bottom of the form. Your electrom be used as verificat Upon receipt of an on-site revisit of you validate that substaregulations has bee your verification. Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accurace The assessment moresident's status. This REQUIREMENT by: Based on interview facility failed to acconditive facility failed to acconditive for urinary Findings include: The Centers for Me Long-Term Care Re Instrument (RAI) 3. 10/2017, identified to be completed wir updated, accurate phealth status." Fur several coding instrument	acceptable electronic POC, an ur facility will be conducted to initial compliance with the en attained in accordance with sments cy of Assessments. ust accurately reflect the NT is not met as evidenced v and document review, the urately code the Minimum 1 of 1 residents (R4)		41 Preparation and executi response and plan of cor constitute admission or a provider of the truth of th or conclusions set forth i of deficiencies. The plar prepared and/or execute it is required by the provi and state law. For the pr allegation that the center substantial compliance w requirements of participa response and plan of cor constitutes the centers a compliance in accordance 7305 of the State Operat	rrection does not agreement by the le facts or alleged in the statement of correction is ad solely because sion of federal urposes of any is not in with federal ation, this rrection llegation of ce with section	12/29/17

Facility ID: 00019

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TATEMENT	OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245278	B. WING		12/01/2017	
-	PROVIDER OR SUPPLIER	- HOWARD LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	HOWARD LAKE, MN 55349 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 641	days)." R4's admission MD had intact cognition Diagnoses," of the diagnosis' for R4 wi selected for a UTL day period. When interviewed of stated she had a UT however, had no re she felt her health w R4's progress note had a history of urin however, "does not is continent." R4's medical record any evidence R4 had diagnosed with one admission to the fac When interviewed of assistant director of completed the MDS urine culture obtain just prior to her admi it was negative for i even been started. computer system h answer on the MDS however, again reitt Further, ADON stat would be completed code the MDS accu	S dated 9/19/17, identified R4 . Further, "Section I - Active MDS listed several active nich included having I2300 surrently or within the last 30 on 11/28/17, at 10:18 a.m. R4 TI a "couple years" prior, cent infections since adding vas good. dated 9/21/17, identified R4 hary tract infection (UTI), have a current diagnosis and d was reviewed and lacked ad a current UTI or had been in the 30 days prior to	F 64	 F641-Accuracy of Assessments 1. R4's MDS was modified on Th November 30th to reflect her acc health status and that she did no UTI. 2. All current residents who have diagnosis of UTI coded on the m recent MDS will be reviewed to e MDS is coded accurately, to reflecurrent health status of UTI. 3. MDS coordinator will be provid re-education by DON or designe 12/29/17 regarding active diagno entered upon admission and pro section I MDS coding. 4. The DON or designee will con MDS Section I audits for R4 and other residents to ensure they ar accurately coded weekly X 4, the monthly X 3. Audit results will be reviewed by the facility QAPI con for further recommendations. 	aursday, curate t have a an active ost nsure ect their led with e by sis per duct random e	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTIDI	E CONSTRUCTION). 0938-039 TE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		245278	B. WING			/01/2017
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD	E	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		I13 13TH AVENUE IOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 641	Continued From pa care of the resident	-	F 641			
F 657 SS=D	11/2015, identified a assessments are co appropriate regulati individual who compassessment to "sign that portion."		F 657			12/29/17
	 §483.21 (b)(2) A corbe- (i) Developed within the comprehensive (ii) Prepared by an includes but is not lie (A) The attending p (B) A registered nurresident. (C) A nurse aide witresident. (D) A member of for (E) To the extent protection of the resident and the resident and the resident of the resident for the resident of the resi	interdisciplinary team, that imited to hysician. rse with responsibility for the th responsibility for the od and nutrition services staff. acticable, the participation of e resident's representative(s). Is the included in a resident's e participation of the resident epresentative is determined he development of the te staff or professionals in mined by the resident's needs				

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STATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		245278	A. BUILD				
	PROVIDER OR SUPPLIER	I	STREET ADDRESS, CITY, STATE, ZIP CO 413 13TH AVENUE HOWARD LAKE, MN 55349			12/01/2017 DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 657	by: Based on interview facility failed to revi urinary incontinence was identified with Findings include: R6's most recent qui identified R6 was co limited assistance w MDS identified R6 was co urine (less than sew R6's care plan date self care performan and limited mobility indicate she was in on her MDS. During interview on assistant (NA)-C st shift and R6's was when she was work During interview 11 nurse (RN)-A stated incontinent of urine identified and addre A facility Comprehe Conferences policy purpose of creating person-centered ca The policy directed reviewed when eac	NT is not met as evidenced v and document review, the se the care plan to include e for 1 of 1 residents (R6) who urinary incontinence. uarterly MDS dated 9/20/17, ognitively intact and required with toileting. Further, the was occasionally incontinent of ven episodes of incontinence). ed 9/28/17, identified R6 had a nee deficit related to fatigue v. The care plan did not continent of urine as identified 11/30/17, at 1:35 p.m. nursing ated that she worked the day usually incontinent twice a shift king. /30/17, at 1:59 p.m. registered d R6 was occasionally and it should have been essed on her care plan. ensive Care Plan and Care v dated 9/17, identified a	Fé	557	 F657-Care Plan Timing and Revisilevel 1. R6's care plan was updated 12/1 reflect resident current health statu urinary incontinence. A new bladde assessment was initiated on 12/18/ will be completed by 12/21/17 and plan will be updated as appropriate 2. All current residents who have be identified per the MDS for bladder incontinence have been reviewed the ensure that all assessments and pl care documentation have been comper facility policy and procedure. 3. The DON or designee will provid re-education on comprehensively assessing/re-assessing and care p for urinary incontinence per GSS per and procedure. 4. The DON or designee will condumentation the base of their residents weekly X 4, and the monthly X 3 to ensure care plans restheir urinary continence needs. Auresults will be reviewed by QAPI Committee for further recommendation and procedure. 	8/17 to s for r (17 and care · een an of npleted e lanning olicy ct en eflect udit	

If continuation sheet Page 5 of 33

(EACH DEFICIENCY		B. WING	·	COMPL	LETED	
SUMMARY STA (EACH DEFICIENCY	- HOWARD LAKE	Ş				
SUMMARY STA (EACH DEFICIENCY				12/0 1	1/2017	
SUMMARY STA (EACH DEFICIENCY			STREET ADDRESS, CITY, STATE, ZIP CODE			
(EACH DEFICIENCY		413 13TH AVENUE HOWARD LAKE, MN 55349				
REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	-	(X5) COMPLETIO DATE	
•	-	F 657				
Free of Accident Ha	zards/Supervision/Devices	F 689		1	2/29/17	
The facility must en §483.25(d)(1) The r	sure that - esident environment remains					
supervision and ass accidents. This REQUIREMEN	sistance devices to prevent					
Based on observat eview, the facility fa eassess and devel adequate supervisio unsupervised smok	ailed to comprehensively op interventions to provide on and safety with ing for 1 of 1 residents (R8)		1. R8's care plan was updated on 11/29/17 to reflect safety hazards wh	en		
and skin. This resu IJ) situation, substa who remained at ris	Ited in an immediate jeopardy andard quality of care, for R8 k for burns and serious injury		risk assessment completed on 11/29 Smoking cessation offered and decli by R8 11/29/17. Care plan was upda	/17. ned ated		
R8 had sustained re ourns to his clothing smoking. Although knowledge of these	and skin from unsupervised direct care staff had incidents, they had not been		facility policy and procedure. Occupa Therapy conducted a smoking safety evaluation on 11/30/17 and 12/1/17 t	itional /		
eassessed and inte provide adequate sa unsupervised smok p.m. the director of	erventions developed to afety with independent, ing. On 11/29/17, at 5:06 nursing (DON) and director of		adaptive smoking equipment to incre safety. Cognitive testing was also of R8 declined any adaptive equipment cognitive testing results showed no	fered.		
	heeds/status chang Free of Accident Ha CFR(s): 483.25(d)(483.25(d) Acciden The facility must en A83.25(d)(1) The r as free of accident l 483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on observat eview, the facility fa eassess and devel adequate supervisio unsupervised smok dentified to have cir and skin. This result by situation, substat who remained at ris with unsupervised s fhe IJ began on 11, 8 had sustained re- provide adequate sa addressed and R8 w eassessed and R8 w eassessed and R8 w provide adequate sa unsupervised smok born, the director of environmental servi J for R8. The IJ wa	This REQUIREMENT is not met as evidenced	 Free of Accident Hazards/Supervision/Devices Free of Accident Hazards/Supervision/Devices FR(s): 483.25(d)(1)(2) FA83.25(d) Accidents. Fhe facility must ensure that - FA83.25(d)(1) The resident environment remains as free of accident hazards as is possible; and FA83.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document eview, the facility failed to comprehensively eassess and develop interventions to provide adequate supervision and safety with unsupervised smoking for 1 of 1 residents (R8) dentified to have cigarette burns on their clothing and skin. This resulted in an immediate jeopardy IJ) situation, substandard quality of care, for R8 who remained at risk for burns and serious injury with unsupervised smoking. The IJ began on 11/28/17, when it was identified R8 had sustained repeated incidents of cigarette burns to his clothing and skin from unsupervised smoking. The IJ began on 11/28/17, when it was identified R8 had sustained repeated incidents of cigarette burns to his clothing and skin from unsupervised smoking. Although direct care staff had snowledge of these incidents, they had not been addressed and R8 was not comprehensively eassessed and interventions developed to provide adequate safety with independent, unsupervised smoking. On 11/29/17, at 5:06 0.m. the director of nursing (DON) and director of environmental services (DES) were notified of the J for R8. The IJ was removed on 12/1/17, at 	 F 689 <	 Feeds/status changes." Free of Accident Hazards/Supervision/Devices F 689 F 868 F 868 F 868 F 868 F	

Facility ID: 00019

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			()	E SURVEY PLETED
	245278	B. WING _		12/0	01/2017
PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
Continued From pa	ige 6	F 68	39		
an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D).			score on 9/13/17 was 15	5/15 indicating he	
9/13/17, identified F displayed verbal be yelling, cursing) and of rejection of care. included quadripleg and muscle weakne extensive assistant (ADLs), total assist and currently used displayed no skin te degree) or other op Further, R8's Medic 11/29/17, identified spasms and contra (shortening or hard or other tissues ofter rigidity of a joint) to R8's last completed dated 9/14/16, iden tobacco and smoke all hours (i.e. morni desire to quit. R8 v regarding daily life i demonstrated no vi did have dexterity of his/her ability to sm	R8 had intact cognition, havioral symptoms (i.e. d did not display any episodes R8's medical diagnoses gia (paralysis of all four limbs) ess. Further, R8 required ce with activities of daily living ance from staff for transfers, tobacco products, however, ears, burns (2nd or 3rd een lesions on his skin. cal Diagnosis listing printed R8 had a history of muscle cture of the muscle(s) ening of the muscles, tendons en leading to deformity or an unspecified site. d Tobacco Use Assessment tified R8 currently used ed over 10 times a day during ng, afternoon, night) with no vas able to make decisions independently and sion impairment(s), however, concerns which, "would affect oke or use tobacco products"		 smokes. Any future residents that elect to be admitted center's non-smoking performance of assessed for smoking signature of any changes noted in reforming safety hazards immediately. Laundry signature of any changes noted in reforming safety hazards immediately. Laundry signature of any changes of any resident personal clothin. 4. Audits will be conducted residents that smoke we monthly X 3 to ensure signature of any addresse Audits will be conducted ensure quarterly smokin completed and addresse Audit results will be revised. 	idents who smoke l despite the olicy will be afety, and person II be implemented. ucation for staff 11/30/17 and l until all staff were ics of education TERACT stop and f communicating sidents; and or injuries staff will notify r changes found in ng. ted for R8 and any eekly X 4, then kin checks are ed appropriately. I quarterly X 3, to ig assessment is ed appropriately. ewed by the QAPI	
,	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa an isolated scope a actual harm with po harm (Level D). Findings include: R8's annual Minimu 9/13/17, identified F displayed verbal be yelling, cursing) and of rejection of care. included quadripleg and muscle weakne extensive assistant (ADLs), total assist and currently used displayed no skin te degree) or other op Further, R8's Medic 11/29/17, identified spasms and contra (shortening or hard or other tissues ofter rigidity of a joint) to R8's last completed dated 9/14/16, iden tobacco and smoke all hours (i.e. morni desire to quit. R8 v regarding daily life i demonstrated no vi did have dexterity of his/her ability to smore	IDENTIFICATION NUMBER: 245278 PROVIDER OR SUPPLIER AMARITAN SOCIETY - HOWARD LAKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). Findings include: R8's annual Minimum Data Set (MDS) dated 9/13/17, identified R8 had intact cognition, displayed verbal behavioral symptoms (i.e. yelling, cursing) and did not display any episodes of rejection of care. R8's medical diagnoses included quadriplegia (paralysis of all four limbs) and muscle weakness. Further, R8 required extensive assistance with activities of daily living (ADLs), total assistance from staff for transfers, and currently used tobacco products, however, displayed no skin tears, burns (2nd or 3rd degree) or other open lesions on his skin. Further, R8's Medical Diagnosis listing printed 11/29/17, identified R8 had a history of muscle spasms and contracture of the muscle(s) (shortening or hardening of the muscles, tendons or other tissues often leading to deformity or rigidity of a joint) to an unspecified site. R8's last completed Tobacco Use Assessment dated 9/14/16, identified R8 currently used tobacco and smoked over 10 times a day during all hours (i.e. morning, afternoon, night) with no desire to quit. R8 was able to make decisions regarding daily life independently and demonstrated no vision impairment(s), however, did have dexterity concerns which, "would affect his/her ability to smoke or use tobacco products"	OF DEFICIENCIES FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 245278 B. WING PROVIDER OR SUPPLIER 245278 AMARITAN SOCIETY - HOWARD LAKE ID PRECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 6 an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). F 68 Findings include: R8's annual Minimum Data Set (MDS) dated 9/13/17, identified R8 had intact cognition, displayed verbal behavioral symptoms (i.e. yelling, cursing) and did not display any episodes of rejection of care. R8's medical diagnoses included quadriplegia (paralysis of all four limbs) and muscle weakness. 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R8 was able to make decisions regarding daily life independently and demonstrated no vision impairment(s), however, did have dexterity concerns which, "would affect	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLER/LLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 245278 B. WING 245278 STREET ADDRESS, CITY, STATE, J. 413 13TH AVENUE HOWARD LAKE AMARITAN SOCIETY - HOWARD LAKE STREET ADDRESS, CITY, STATE, J. 413 13TH AVENUE HOWARD LAKE, MN 55349 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 6 an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). F 689 Findings include: 2. R8 is the only residen smokes. Any future res rassistance with activities of daily living (ADLs), total assistance from staff for transfers, and currently used tobacco products, however, displayed verbal behavioral symptoms (i.e. yelling, cursing) and did not display any episodes included quadriplegia (paralysis of all four limbs) and muscle weakness. Further, R8 required extensive assistance with activities of daily living (ADLs), total assistance from staff for transfers, and currently used tobacco products, however, displayed no skin tears, burns (2nd or 3rd degree) or other open lesions on his skin. Further, R8's Medical Diagnosis listing printed 11/29/17, identified R8 had a history of muscle spasms and contracture of the muscle(s) (shortening or hardening of the muscles, tendons or other tissues often leading to deformity or resident personal clothin resident sthat smoke we monthly X 3 to ensure s completed and addressi. Audits will be conducte ensure quarterly smokin completed and addressi. Audits will be conducte ensure quarterly smokin completed and addressi. </td <td>OP DEFICIENCIES F CORRECTION (X1) PROVIDERSUPPLIER(CLA ABULDING (X2) MULTIFLE CONSTRUCTION (X3) DATI A BULDING PROVIDER OR SUPPLER 245278 B. WING 12/// AMARITAN SOCIETY - HOWARD LAKE B. WING 12/// MARITAN SOCIETY - HOWARD LAKE PROVIDER SOLVY, STATE, ZIP CODE 413 13TH AVENUE (EACH DEFICIENCY MUST BE PRECIEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRECINC RESPECTIVE CODE TO THE APPROPRIATE DEFICIENCY PROVIDER SOLVY, STATE, ZIP CODE Continued From page 6 an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). F 689 11/30/17, which R8 declined. His BIM score on 9/13/17 was 15/15 indicating he is capable of making these decisions. R8's annual Minimum Data Set (MDS) dated 9/13/17, identified R8 had intact cognition, displayed vorbal behavioral symptoms (i.e. 9/13/17, identified R8 had intact cognition, displayed verbal behavioral symptoms (i.e. 9/13/17, identified R8 had intact cognition, displayed no skin tears, burs (2nd or 3rd degree) or other open lesions on his skin. 3. DON provided 1:1 education for staff present on 11/29/17, and continued until all staff were educated (12/47). Topics of education included: using the eINTERCAT stop and watch; the importance of comunicating any changes noted in residents; and reporting safety hazards or injuries infolded for AB and a history of muscle spasms and contracture of the muscle(s) (shortening or hardening of the muscles), regarding dail to a concurse August be conducted for R8 and any resident personal clothing. 4. Audits will be co</td>	OP DEFICIENCIES F CORRECTION (X1) PROVIDERSUPPLIER(CLA ABULDING (X2) MULTIFLE CONSTRUCTION (X3) DATI A BULDING PROVIDER OR SUPPLER 245278 B. WING 12/// AMARITAN SOCIETY - HOWARD LAKE B. WING 12/// MARITAN SOCIETY - HOWARD LAKE PROVIDER SOLVY, STATE, ZIP CODE 413 13TH AVENUE (EACH DEFICIENCY MUST BE PRECIEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRECINC RESPECTIVE CODE TO THE APPROPRIATE DEFICIENCY PROVIDER SOLVY, STATE, ZIP CODE Continued From page 6 an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). F 689 11/30/17, which R8 declined. His BIM score on 9/13/17 was 15/15 indicating he is capable of making these decisions. R8's annual Minimum Data Set (MDS) dated 9/13/17, identified R8 had intact cognition, displayed vorbal behavioral symptoms (i.e. 9/13/17, identified R8 had intact cognition, displayed verbal behavioral symptoms (i.e. 9/13/17, identified R8 had intact cognition, displayed no skin tears, burs (2nd or 3rd degree) or other open lesions on his skin. 3. DON provided 1:1 education for staff present on 11/29/17, and continued until all staff were educated (12/47). Topics of education included: using the eINTERCAT stop and watch; the importance of comunicating any changes noted in residents; and reporting safety hazards or injuries infolded for AB and a history of muscle spasms and contracture of the muscle(s) (shortening or hardening of the muscles), regarding dail to a concurse August be conducted for R8 and any resident personal clothing. 4. Audits will be co

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	01/18/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245278	B. WING		12/	01/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	to get outside or ba assessment listed a which identified R8 cigarette and conta need for adaptive e choices to select in cigarette holder, su assistance. The op was checked. Furt R8 had no history of cigarette, falling as himself or clothing, tobacco-related bel assessment lacked location for R8's sm cigarette or ash dur attempted intervent or unsuccessful for R8's care plan print bilateral hand contr injury along with lim to quadriplegia. R8 without staff assista device, and demon concerns along with towards staff." Fur R8 used tobacco p listed a goal of, "[R8 products in designa burns." The only in this goal was identi tobacco use, cigare on my wheelchair a plan lacked any fur past offered or refu R8's unsupervised	ack in the center. The a section labeled, "Safety," was able to light his own ained a question of, "Resident equipment," along with several actuding a smoking apron, apervision, one to one otion for, "None of the above," ther, the assessment identified or incidents with dropping the leep while smoking, burning or other unacceptable havior(s) in the past. The d any information on physical noking, his ability to hold a ring use, or any history of tions which had been refused r R8. ted 11/29/17, identified R8 had ractures due to a spinal cord nited physical mobility related 8 was unable to transfer ance and a mechanical lift ustrated potential mood h notation he, "easily angers ther, the care plan identified roducts off facility grounds and 8] will safely use tobacco ated area. I will be free from nervention listed to help meet ified as, "I am independent with ettes and lighter are in a pouch and always with me." The care ther information, including any used interventions, pertaining to				

Facility ID: 00019

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	0938-039 E SURVEY PLETED
		245278	B. WING			12/	01/2017
	PROVIDER OR SUPPLIER	- HOWARD LAKE		41	REET ADDRESS, CITY, STATE, ZIP CODE I 3 13TH AVENUE DWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 689	smoke. R8 wheele electric wheelchair hallway. R8 had vi fingers on both har himself past the rec of the facility and d facility prior to exitin down to the end of remained on the nu removed an opene his gray colored ho and turned it upside cigarette and stand and metal sparkwh R8 picked up the c pointer finger and p rest of his fingers b towards his palm(s to light the cigarette however, was unab R8 stated he had, ' his cigarettes in the mouth. R8 then us cigarette with his th remaining fingers v towards the palm. hold the lighter. R8 abdomen with both several times with being held immedia he attempted to ligh his mouth. R8 lit th hand to bring it to h R8 stated he smok going outside on hi hour and a half or s	and proceeded down the sible contractures of his ods. R8 proceeded to wheel ception desk in the main lobby id not sign himself out of the ng the nursing home and going the driveway, however, he ursing home property. R8 d package of cigarettes from oded sweatshirt front pocket e down on his lap exposing a lard lighter with a plastic body eel. garette using his thumb and placed it into his mouth, the eing contacted inwards). R8 attempted several times e in his mouth using the lighter, ple to after several attempts. Tots of years practice," lighting e wind and removed it from his ed his right hand to hold the numb and first finger as the vere contracted inwards R8 used his opposite hand to 8 then pressed into his hands while flicking the lighter visible sparks and open flame ately next to his sweatshirt as nt the cigarette and bring it to ne cigarette and used his right	F 6	89			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY
				NG		
	PROVIDER OR SUPPLIER	245278	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12	/01/2017
	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	JLD BE	(X5) COMPLETIC DATE
F 689	"cigarette cherry [recigarette]" will fall o his skin due to poor downward. R8 stat couple weeks prior visible, light brown surrounded by light aspect of his first fir area was approxim diameter and R8 ac just like the one he R8 then lifted up his showed a visible, a diameter, hole in th the sweatshirt. R8 ash which had falle R8 stated none of t about his smoking ap "heck no." R8 state complication or pot fire, he would use h nursing home and a smoking his cigaret from his mouth usin the remaining filter did not extinguish th of it. R8's most recently V2 dated 11/21/17, pressure ulcer on h lacked any identifie right hand.	d hot ash on the end of the lit ff and he is unable to feel it on r sensation from his shoulders ed he last burned himself a and showed the surveyor a colored scabbed area pink colored skin on the inner nger of his right hand. The ately 0.5 centimeters (cm) in dded he had sustained burns, showed, before. In addition, s gray colored sweatshirt and pproximately 2.5 cm in e center of the front side of stated it was from a cigarette n on it from awhile prior. he staff had spoken to him nor do they come outside with es, however, when questioned oron being used he replied, ed if he were to have a entially start his clothing on his cell phone to call the ask for help. R8 finished te at 2:08 p.m. and removed it ng his right hand and tossed and butt into the street. R8 he cigarette before disposing completed Skin Observation - identified R8 had a chronic is gluteal fold(s), however d burns or skin injuries on his	F 6			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245278	B. WING _		12/01/2017	
	PROVIDER OR SUPPLIER	- HOWARD LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349		
(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 CORRECTI	D BE	(X5) COMPLETIC DATE
F 689	typically "gone a fe stated she had new outside to observe had noticed burn h The most recent bu jacket, however, N. these were old or n owned the coat for R8 was independe did not help him, no adaptive devices w knowledge. During interview or stated R8 smoked "not supposed to," wanted to smoke w they had to be able assistance becaus NA-B stated she has burns on his hands hot and creates a b "every couple mont observed a burn or three months prior motion on his hands always notice them had reported these however, was unab had been reported the surveyor and N to observe his burn check for additional left the facility and "	s up for the day and then is w hours" around town. NA-A rer personally helped or gone R8 while smoking, however, oles in his clothing before. Urn holes being on his winter A-A stated she was not sure if new burn holes though as he awhile. Further, NA-A stated int with his smoking and staff or did R8 wear or use any hile smoking to her 11/28/17, at 2:28 p.m. NA-B independently and staff were, help him as if a resident while living at the nursing home, to do it without staff e, "That's just the policy here." ad noticed R8 to have cigarette before because it "gets too olister," adding this happened ths." NA-B stated she last n R8's hand approximately when completing range of l(s) further adding, "that's how I u." Further, NA-B stated she burns to the nurse(s), ole to recall anyone specific it to. On 11/28/17, at 2:34 p.m. A-B attempted to visit with R8 and go through his clothing to I burn holes, however, R8 had was not available. 11/29/17, at 8:49 a.m. laundry ated she completed all	F 6			

		& MEDICAID SERVICES	1			. 0938-039
-	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245278	B. WING		12/	01/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 689	smoked adding his functional." LA-A st burn holes in his clo she doesn't "look at turned and removed which had been har room. R8 had a pla several holes in the these were "wear he the gray colored sw prior, when observe and inspected it. L/ of the sweatshirt an a cigarette burn." F currently was not in completing his laun should be checking When interviewed of trained medication a smoker and goes "o property" to smoke TMA-A stated R8 w and was able to saf lighter without assis of any burns on R8' stated staff should " charge nurse and c (an 'early warning to identified while carin stated she "would a the cigarette and/or was smoking as R8 himself when smok out using a paper lo smoke. TMA-A sho which identified sev failed to sign himse	ge 11 hands "aren't 100 percent ated she had never noticed othing before, however, added them that close." LA-A d several pieces of clothing nging on a rack in the laundry in green colored shirt with front. LA-A stated she felt oles" though. LA-A removed eatshirt R8 had worn the day ed to smoke by the surveyor, A-A verified a hole in the front d stated, "I would say that was further, LA-A stated she specting R8's clothing when dry, however, added "I guess I [his] clothes better." on 11/29/17, at 9:33 a.m. aide (TMA)-A stated R8 was a down to the end of the after he gets up for the day. as independent with smoking ely use cigarettes and a tance. TMA-A was unaware s skin or clothing, however, l'report it right away" to the omplete an Stop-and-Watch pol' used when a change is ng for a resident). TMA-A ssume" R8 would just put out fire, if one occurred, while he took "full responsibility" for ing. R8 was to check in and og when going outside to owed this log to the surveyor eral empty spaces when R8 If back into the facility when A reviewed the record and	F 6	89		

Facility ID: 00019

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		AND HUMAN SERVICES			FORM	01/18/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245278	B. WING		12/	01/2017
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		113 13TH AVENUE IOWARD LAKE, MN 55349		
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	stated R8 "should b record as "he's bee TMA-A stated staff he returned from sr around town. An undated, blank ' Warning Tool" was instructions to com identified a change resident," then to pu follow-up. Some ex to be watchful for in usual," and, "Chang R8's medical record these had been cor skin or clothing. R8's medical record progress note dated smoke and did not time further adding risk/benefit of all ec makes." The note what information re been provided, nor were discussed and unsupervised smok An electronic progri identified R8 "contin cigarettes independ lighter at all times." observation, assess how this determina unsupervised smok R8's physician prog	be" filling out the sign in/out in told to" use it. Further, did not inspect R8's skin when moking or from his outings 'Stop and Watch Early provided. The form listed plete one when, "you have while caring for or observing a rovide the form to a nurse for camples provided on the form included, "Seems different than ge in skin color or condition." d lacked any evidence one of mpleted for any burns in his d was reviewed. A handwritten d 4/16/13, identified R8 to want to pursue quitting at the him to, "understands lucation and choices that he lacked any information on lated to safe smoking had what interventions, if any, d/or refused to ensure safe sing. ess note dated 6/21/17, nues to be safe to smoke his dently and hold them and the The note lacked any sment or dictation to describe tion had been made of R8's	F 689			

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STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA) <u>. 0938-039</u> TE SURVEY MPLETED	
		245278	B. WING		10	01/0017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12	/01/2017	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE	
F 689	reviewed and ident physician a total of period. R8 was ide on each of the visit identified as having remain on Valium (anxiety and muscle spasms". All of the dictation regarding unsupervised smol Further, the medica reassessment of R abilities despite obt skin described by N occupational therap smoking; nor evide interventions to pro- smoking. In addition, the reco- recorded incident re- burns sustained on described by NA-A the facility had atter collaboration with F interventions or the unsupervised smol- additional notes or regarding these iter During interview on stated she was awa was the "first thing gets up." R8 was in and when he leave for himself then." N	ified R8 had been seen by his seven times in the 10 month entified as a "current smoker" s. On 2/14/17, R8 was g quadriplegia and needed to medication used to treat e spasms) "for control of e provided notes lacked any smoking related injuries or his	F 6				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245278	B. WING _		12/	01/2017
	PROVIDER OR SUPPLIER	- HOWARD LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349		
(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	D BE	(X5) COMPLETIC DATE
F 689	a nice thing to have report incidents, lik burning himself, to When interviewed NA-F stated staff "o smoking. R8 goes street and, "whatev building, we don't k staff were not comp or other interventio asking him "how wa On 11/29/17, at 1:0 (RN)-C was intervie quadriplegic, had p fingers on both har himself out of the b smoke as he was u grounds. RN-C wa R8's clothing or ski smoking as "nothin if staff are noticing it should be reporte so the physician ca report can be comp R8 was independe lighter, however, ac him smoke person had been assessed before the survey. During interview or stated she had wor approximately two smoked "since he o years prior. R8 typ	ore, however, felt it would "be e" as R8 was not someone to e dropping the cigarette or the staff. on 11/29/17, at 12:54 p.m. don't help him [R8]" with outside and smokes on the ver happens outside of this snow it." Further, NA-F stated pleting any formal skin checks ns upon his return, but merely	F 68	39		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 01/18/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245278	B. WING			12/	01/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			413 13TH AVENUE IOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	grounds, however, just go down to the smoke in the later of she "would assume been done on adm not sure adding she safe unsupervised she was unaware F cigarette burns on I not been reported t until now. RN-B sta ever been consulte R8's unsupervised I've been here." Fu himself while smok should do somethin "we got to be keepi When interviewed of stated she was awa however, added sh location(s) he was don't feel like I'm hi person" when he le was unaware R8 ha his hand, nor was s being observed in F with R8's paralysis contributed that he burning his skin or staff should be repo so it could be addre safety." On 11/29/17, at 2:1 nursing (ADON) wa she had worked at	smoke on the campus RN-B added at times R8 will end of the driveway and evening hours. RN-B stated e" a smoking assessment had ission for R8, however, was e had never assessed him with smoking before. RN-B stated R8 had been sustaining his clothing and skin as it had to her or raised as a concern ated she did not think OT had ed in the past to help address smoking adding, "not since urther, RN-B stated R8 burning ing made her "feel like I ng right now" to help him as	F	589			

		AND HUMAN SERVICES			FORM	01/18/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		(X3) DATE	E SURVEY PLETED
		245278	B. WING		12/0	01/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	SAMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	time. R8 was last a smoking in Septem 9/14/16), and she fe ADON stated R8 "u everything" includin however, she was u cigarette in 2016 wi ADON stated she w burning his clothes adding the NA staff concerns to her. If concern with a resid clothing and/or on t tool should have be addressed and R8 safety with smoking was unaware if any burns with R8, nor if to help develop inte safe with his unsup A provided UDA (us Reference Guide da which identified it has prior to survey. Th assessments along when to complete th Assessment was lis completed by a reg " on admission for products; required fu use tobacco product completed; or when ability, judgment, m mobility." Further, t	assessed by ADON for aber 2016 (assessment dated elt he was safe at the time. uses his thumbs a lot with by lighting his cigarettes, unable to recall how R8 lit the hen she last assessed him. vas unaware R8 had been and skin with his cigarettes had never reported those the NA staff identify a new dent, like cigarette burns in their skin, a stop-and-watch been completed so it could be could be reassessed for his g. Further, ADON stated she rone had discussed the risk of had OT ever been consulted erventions to ensure R8 was	F 689			

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY
ND PLAN (OF CORRECTION	DENTIFICATION NUMBER:		G	COM	IPLETED
		245278	B. WING _		12/	01/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 689	During interview or stated she was new unaware of the fac regarding having a completed. OT-Ar and stated there we consulted for R8 fo however, OT-A sta compensatory met R8 did not have us his cigarettes and p his clothing on fire; cognition, looking a skills while using a comprehensive ass sensation and OT- even know he's be stated if someone sensation was sus unsupervised smol appropriate to revie functional deficits a On 11/29/17, at 2:4 (DON) was intervieu unsupervised smol working at the nurs her knowledge R8 interventions from "his own person ar well pleases," and things, then being to day and yelling at t interventions offere smoking were done and they just had m	n 11/29/17, at 2:28 p.m. OT-A w to the nursing home and ility's policies and procedures smoking safety assessment reviewed the therapy record as no history of OT being or his unsupervised smoking, ted there were definitely "some hods" which could be used so e his abdomen or chest to light potentially burn himself or start including assessing his at his dexterity and handling cigarette and "just do a sessment." R8 had impaired A questioned, "Does he [R8] ing burned?" Further, OT-A with impaired dexterity and taining cigarette burns with king, it would be OT ew them so as to "assess				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 01/18/2018 APPROVED : 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				E SURVEY IPLETED	
		245278	B. WING			12/	01/2017	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 689	have completed a s could be treated and Further, DON state responsible to ensu- when he signs hims own person. Durin 11/29/17, at 5:06 p. made to the State a potential neglect fo sustaining cigarette smoking. A facility Smoke-Fr 3/2016, identified it smoking inside Goo buildings was not p "All residents/client products will be ass listed which directe designate acceptable resident smoking w for staff member of residents who use Use Assessment co assessments would has a change in co dexterity or mobility direction or proced how to address cig and/or skin, should A Smoking and Tok identified it applied purpose of reaffirm safe and healthy er residents and visito smoking shall be d	g or on his skin, they should Stop-and-Watch so the burns ad staff "can be looking at it." ad the facility was ultimately ure R8 was safe, however, self out and leaves, he was his g a follow up interview on .m. DON stated a report was agency (SA) regarding r R8 since he had been e burns from unsupervised ee Locations policy dated applied to skilled care and od Samaritan Society (GSS) permitted. The policy directed, s who smoke or use tobacco sessed." A procedure was d staff members would ble outdoor locations for which "must be readily visible oservation." Upon admission, tobacco will have a Tobacco ompleted. Further, additional d be completed if a resident gnition, judgment, manual A. The policy lacked any ure for staff to implement on arette burn(s) on clothing	F	\$89				

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
		245278	B. WING		12	2/01/2017	
	PROVIDER OR SUPPLIER	- HOWARD LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETIO DATE	
F 689	smoke must not por themselves or othe direction or proced how to address safe burn(s) on clothing occur. No further policies smoking safety or of provided. The IJ which began 12/1/17, at 2:19 p.r implemented a rem following: - R8 was reassess smoking which idea apron, cigarette ho one assistance. R interventions, howe evaluation for safet identified R8 to now related incidents in incident of burning report as it was "no progress note for F dated 11/29/17, at ADON. ADON exp the burn(s) for pote demonstrated how as reporting he had observed by the su have gotten a differ with the shitty one a	age 19 staff. Further, "Residents who bes a safety hazard to ers." The policy lacked any ure for staff to implement on fety with smoking nor cigarette and/or skin, should they or procedures related to unsupervised smoking were n on 11/28/17, was removed on m. after the facility successfully noval plan which included the ed by nursing for unsupervised ntified he required a smoking lder, supervision and one on 8 refused all of these ever, R8 "agreed to [OT ty]." Further, the assessment w have a history of smoking cluding "a self reported his finger" which he failed to ot a big deal." A subsequent R8's smoking reassessment 6:45 p.m. was authored by blained to R8 they had reported ential neglect of care while R8 he smoked. R8 was identified d a "shitty lighter" when inveyor on 11/28/17, and should rent one, "instead of fighting and almost burning my shirt." on was made for R8 to screen, p interventions for safe,	F6				

Facility ID: 00019

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	· · /	IPLETED
		245278	B. WING		12	/01/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	-	F 68	9		
		king. A provided OT Daily ted 12/1/17, identified R8 as				
		ete SCI [spinal cord injury] at				
		l," who had impaired d upper body strength and				
	impaired motor cor	ntrol. OT completed a smoking				
		entified R8 was able to strike m his body, however, "[his]				
	thumb still very nea	ar flame when lighting. Will				
	need to further exp burn." Further, R8	lore options to reduce risk of agreed to trying a				
	plastic-smoking ad	aptor and e-cigarettes, along				
	hot end nears hand	ne cigarette mid-way "before d."				
		f on ensuring cigarette burn(s)				
	on clothing and/or and documented.	skin were immediately reported				
		:01 p.m. to 2:18 p.m. nursing				
		ff were interviewed to ensure provided related to R8's				
		king including ensuring R8's as routinely monitored for				
	potential burn injuri	es, use of the Stop-and-Watch				
		ating changes in resident and documentation standards				
	pertaining to a char	nge in condition.				
F 690 SS=D	Bowel/Bladder Inco CFR(s): 483.25(e)(ontinence, Catheter, UTI 1)-(3)	F 69	0		12/29/17
	§483.25(e) Incontir					
		facility must ensure that ntinent of bladder and bowel on				
	admission receives	s services and assistance to				
		e unless his or her clinical omes such that continence is				
	not possible to mai					

Facility ID: 00019

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		AND HUMAN SERVICES				FORM /	01/18/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245278	B. WING			12/0	01/2017
	PROVIDER OR SUPPLIER	- HOWARD LAKE		4	REET ADDRESS, CITY, STATE, ZIP CODE 13 13TH AVENUE OWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	incontinence, based comprehensive ass ensure that- (i) A resident who e indwelling catheter resident's clinical of catheterization was (ii) A resident who indwelling catheter is assessed for rem as possible unless demonstrates that of and (iii) A resident who receives appropriat prevent urinary trac continence to the e §483.25(e)(3) For a incontinence, based comprehensive ass ensure that a reside receives appropriat restore as much no possible. This REQUIREMEN by: Based on observat review the facility fa reassess 1 of 1 res urinary continence. Findings include: R6's quarterly Minin 6/21/17, indicated s	resident with urinary d on the resident's sessment, the facility must nters the facility without an is not catheterized unless the ondition demonstrates that necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder e treatment and services to at infections and to restore extent possible. A resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel e treatment and services to arreal bowel function as NT is not met as evidenced tion, interview and document ailed to comprehensively idents (R6) with a change in	F 6	90	F690-Bowel/Bladder Incontinence, Catheter, UTI - D level 1. R6's care plan was updated 12/1 reflect resident current health status urinary incontinence. A new bladde assessment was initiated on 12/18/ will be completed by 12/21/17 and o plan will be updated as appropriate	8/17 to s for r (17 and care	

Facility ID: 00019

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		& MEDICAID SERVICES					0938-039
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · /	E SURVEY PLETED
		245278	B. WING _			12/0	01/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			13 13TH AVENUE OWARD LAKE, MN 55349		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 690	further indicated sh urine and was not of quarterly MDS date now occasionally in on a toileting progra assessment (CAA) had urinary urgency toileting. The CAA diuretics and did no R6's care plan date hypertension, type if heart failure. The ca activity of self care fatigue and limited indicate she was in R6's Bladder Incom dated 10/2/16, indic than daily with a me absorbent pad. The denied incontinence trouble with it. R6 c episodes document 9/28/16. There we done related to blac Observation dated excoriation to her ri R6's Point of Care incontinence for the was incontinent of ur in the toilet. LPN-A	e was always continent of on a toileting program. R6's of 9/20/17, indicated she was icontinent of urine and was not am. R6's care area dated 3/29/17, indicated she y and need for assist with indicated she received of indicate she was incontinent. ed 9/28/17, indicated she had two diabetes and congestive are plan indicated she had performance deficit related to mobility. The care plan did not	F 69	90	 All current residents who have be identified per the MDS for bladder incontinence have been reviewed te ensure that all assessments and pl care documentation have been com- per facility policy and procedure. The DON or designee will provid re-education on comprehensively assessing/re-assessing and care p for urinary incontinence per GSS pe and procedure. The DON or designee will condu MDS Section H Bowel and Bladder continence audits for R6 and rando other residents weekly X 4, and the monthly X 3 to ensure care plans re their urinary continence needs. Au results will be reviewed by QAPI Committee for further recommenda 	o an of npleted e lanning olicy ct ct m en eflect udit	

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES		TIDI		MB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245278	B. WING			12/0	01/2017
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG		ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE GULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE		
F 690	Continued From pa	ge 23	Fe	690			
	R6's right and left b	-					
	worked the day shif	5 p.m. CNA-C stated that she t and R6 was usually shift when she worked.					
	(RN)-A stated R6 d assessment after h urine to occasionall stated the facility we they needed to wor performance impro- they wanted more r urine. RN-A further program assessme for quarterly bladde missed. In addition able to print a histo 30 days based on r documentation.	9 p.m. Registered Nurse id not receive a bladder er change from continent of y incontinent of urine. RN-A as aware this was an area k on and it was part of their vement project. RN-A stated esidents to be continent of stated currently the computer nt tool did not provide an alert r assessments so they were RN-A stated they were only ry of incontinence going back hursing assistant					
	the facility failed to minimize the risk of A facility policy Blac 3/17, indicated the bladder patterns, in identify potentially r incontinence and to urinary incontinence programs. The Ass be done quarterly a	change in urinary incontinence reassess the incontinence to further change. Ider Assessment revised purpose is to review/assess continence and frequency, to					

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PRINTED: 01/18/2018
		AND HUMAN SERVICES				FORM	: 01/18/2018 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245278	B. WING _			12/	01/2017
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	·	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			3 13TH AVENUE DWARD LAKE, MN 55349		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 690	to the interventions attaining/maintainir	ation of the residents response and success with ng bladder continence.	F 69				12/29/17
F 880 SS=F	Infection Prevention CFR(s): 483.80(a)(1)(2)(4)(e)(f)		80			12/29/17
	infection preventior designed to provide comfortable environ	stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable					
	program. The facility must es	n prevention and control stablish an infection prevention m (IPCP) that must include, at owing elements:					
	reporting, investiga and communicable staff, volunteers, vi providing services arrangement based	stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards;					
	procedures for the but are not limited t (i) A system of surv possible communic infections before th persons in the facil	eillance designed to identify able diseases or ey can spread to other					

Facility ID: 00019

If continuation sheet Page 25 of 33

						0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245278	B. WING _		12/	01/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 880	communicable dise reported; (iii) Standard and tra- to be followed to pro- (iv)When and how i resident; including k (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos- circumstances. (v) The circumstance must prohibit emplo- disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in or §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must han transport linens so a infection. §483.80(f) Annual r The facility will cond	ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a but not limited to: uration of the isolation, and the isolation should be the sible for the resident under the sible for the resident under the ces under which the facility by ees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact. them for recording incidents facility's IPCP and the aken by the facility.		30		
	This REQUIREMEN by: Based on observat review the facility fa comprehensive infe	NT is not met as evidenced ion, interview and record		F880 Infection Prevention and level 1.&2. All residents had the pot		

Facility ID: 00019

If continuation sheet Page 26 of 33

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	()	E SURVEY PLETED
		245278	B. WING		12/	01/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 880	Continued From pa	ige 26	F 88	0		
		dents in the facility. This had the affect all 27 residents who resided in noted.				
	from June 2017, th The facility provided Report of Resident line present for more on top of the graph infections, the num acquired (nosocom community acquire included the followi number, date admi infection, culture ta agent, antibiotic tre- isolation (yes or no- no). This document designations for syn antibiotics or non-b or fungal infections The facility also pro Review Report, as titled monthly infect summary included types, and identified nosocomial or com entries at the botton "Trends" and "Action A review of these loce The document titled	mptoms not treated with acterial infections such as viral		 3. The facility has impleted for identifying and docurred infections. All infections the attending nurses on the attending nurses will not control nurse when not like infections. The Inferent nurse will utilize the GSS to conduct monthly trends to conduct monthly trends to conduct monthly trends and the developed as approximating staff will be provided by the DON. 4. Audits will be conduct Control nurse to ensure tracking tool is being cobasis when a new infect These audits will be dore then monthly X 3. Audit reviewed by the QAPI commendation. 	menting all s will be noted by he GSS 157 s they occur. The tify the Infection ing two or more action Control S 157 tracking tool ding of infections. viewed by the ly and action plans propriate. All vided education on N by 12/29/17. ted by Infection the GSS Infection mpleted on a daily tion is identified. he weekly X 4, t results will be ommittee for	

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	TOF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	· · /	IPLETED
		245278	B. WING _		12/	01/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 880	categories of infect infections as follow three residents; gas difficile - c. diff. a hi which may cause d respiratory/lung infe infections - two res in one resident. A d Report, dated June who had received a antiviral's in the mo antifungal's and an report, only those re- were listed on the r Monthly Infection C of one nosocomial acquired infections infections, yet six re- the document. A h- titled Trends, identi continued infection 2017), and identifier reflect a "Downwar not included to ider pattern identified. T education on aspira copy learning as we and skin/soft tissue requested, a Data I provided for 6/17. The Monthly Repor four residents were total of four courses categories of infect respiratory/lung infe	age 27 of antibiotic therapy. The ion included the breakdown of s: Prophylactic antibiotic use - strointestinal (clostridium ighly infectious bacterial illness liarrhea) - one resident; ections - three residents; skin idents; and a urinary infection document titled Order Listing 28, 2017, identified residents antibiotics, antifungal's, onth of June. Although tiviral's were noted on the esidents receiving antibiotics eport of infections. The control Report identified a total infection and four community , to total five identified esidents were addressed on and written narrative note, fied the presence of one from the previous month (May ed the number of infections d trend". Additional data was ntify the previous trends or any 'he action plan identified staff ation pneumonia with hard ell as urinary tract infections, e education. Although Review Report was not	F 88			

Facility ID: 00019

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		AND HUMAN SERVICES				FORM	01/18/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245278	B. WING			12/	01/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			13 13TH AVENUE OWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	infection, and two of A hand written narr identified a resolve admission, with ide However, the resid antibiotic use. One skin/soft tissue hea initial log reflected implemented for tra- identified staff educ infection prevention July. A Data Review month of 7/17. The one resident was tr tract infection, whice infection remained document additional discontinue antibion prophylactic antibion the review identifier positive, it did not p previous trends, no data measure, the The document indig reviewed by the QA Performance Impro- and no action was The report dated A residents were trea of three courses of resident was noted categories: respirat infection, and gastr Order Listing Repo there was one resid antibiotic therapy th	total of one nosocomial community acquired infections. ative note titled Trends, d urinary tract infection upon entified negative lab work. ent continued on prophylactic incident was identified as aling without antibiotics. The intravenous antibiotics were eatment. The action plan cation on handwashing and n provided at a staff meeting in w Report was provided for the positive findings identified reated for an upper respiratory ch was nosocomial. The isolated to one resident. The ally noted attempts to tic therapy for a resident on a otic were successful. Although d the data trending was provide a comparison to or did it identify a goal for the goal was "to be determined". cated the information had been API (Quality Assurance ovement) group on 8/25/17,	Fε	80			

Facility ID: 00019

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). 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		245278	B. WING _		12	2/01/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 880	identified one addit antibiotic therapy, a receive antifungal t Infection Control R nosocomial infectio acquired infection. titled Trends, iden alternate sources v identified an episod with no spread of in identified staff re-e precautions related diff. A Data Review month of 8/17. The resident was treated infection which was isolated to one resi included prophylac versus benefit state resident with c. diff positive. The data positive, but no con data measure goal	Listing Report dated 9/1/17, tional resident was treated with and one resident continued to treatment. The Monthly eport identified a total of two ons, and one community A hand written narrative note, tified three infections of with no trends noted. The note de of bronchitis was isolated infection. The action plan ducation on isolation d to recurrent problems with c. w Report was provided for the e positive findings identified one ed for upper respiratory tract is nosocomial, which remained ident. The negative findings tic antibiotic treatment with risk ement noted. It was also noted positive culture will always test review identified trending was mparisons were provided. The continued to indicate it was	F 88	30		
	identified the data provide a comparis it identify a goal for information was no the QAPI group on The Monthly Repor identified seven res antibiotics for a tota therapy. Upon revio	ed". Although the review trending was positive, it did not son to previous trends, nor did the data measure. The sted to have been reviewed by 9/20/17 with no action taken. At for September of 2017 sidents were treated with al of eight courses of antibiotic ew of the entries, it was noted to 8/26/17. The categories of				

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	N	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245278	B. WING			12/	01/2017
	PROVIDER OR SUPPLIER	- HOWARD LAKE		STREET ADDRESS, 413 13TH AVENUE HOWARD LAKE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	DER'S PLAN OF CORRECTIC DRRECTIVE ACTION SHOULI FERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 880	was provided for th antifungal therapy. Report identified a infections, and five infections. A hand w Trends, identified n notation was also n infection was isolat the urinary tract infe acquired, one was "procommunity adm a "situation, backgr recommendation (S provided to physicia interventions imple monitor hand hygie this would be done requested but not p The October 2017, the center identified courses of antibioti infection included th follows: respiratory, gastrointestinal/cole listing report, dated those receiving ant The Monthly Infecti total of two nosoco community acquire narrative note, titled were noted. The ac [influenza]/pneumo noting reeducation precautions/vaccina was provided for th noted a positive da	listing report, dated 10/18/17, listing report, dated 10/18/17, lose receiving antibiotic and The Monthly Infection Control total of three nosocomial community acquired written narrative note, titled to trends were noted. A nade identifying the c. diff. ed. It was noted three of five of ections were community nosocomial, and one was nit." The action plan identified round, assessment, SBAR)" notification was ans, staff educated and mented. A note was written to ene, however, it did identify how . A Data Review Report was provided for the month of 9/17. report of resident infections in d three residents with four c therapy. The categories of he breakdown of infections as /lung - two residents, and on - two residents. An order I 11/13/17, was provided for ibiotic and antifungal therapy. ion Control Report identified a mial infections. A hand written d Trends, identified no trends ction plan identified "flu onia season approaching,		880			

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		AND HUMAN SERVICES				FORM	D: 01/18/2018 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245278	B. WING	à		12	/01/2017
NAME OF I	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	the QAPI team on taken. The November 201 in the center identifiname and first initia additional documer sticky notes there whave received antik dates; 11/12/17, 11 11/27/17. There we provided when the was initially reviewer requested, the Mor and Data Review requested, the Mor and Data Review refutes admitting to the fact received. The DON was monitored through other state of the information on compiled monthly. regarding current in Communication Bot the DON further state of day as it was used trending. In reviewi identified an increat ract infections in 9 monitored for ongo through observation.	ted to have been reviewed by 11/17/17, and no action was 17, report of resident infections fied one resident, with only first al of the last name, with no hts provided. On three pink were four residents identified to biotic therapy on the following /17/17, 11/17/17, and ere no additional documents Infection Control Log book ed 11/28/17. Although hthly Infection Control Report eport was not provided for w on 12/1/17, at 9:43 a.m. the (DON) stated the information s was obtained on residents fility, with lab results recorded if I stated tracking and trending bugh QAPI. The DON stated the infection control log is Staff relayed information		880			

Facility ID: 00019

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PRINTED: 01/18/2018

		AND HUMAN SERVICES				FORM	: 01/18/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY IPLETED
		245278	B. WING			12/	01/2017
NAME OF I	PROVIDER OR SUPPLIER	·			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE			413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	was compared to the there was no docur table titled Residen dated 2017 was pro- January thorough J was provided regar implemented. A facility policy, title 10/17 identified sur analyze, control and infections." The de process as date co establishment of tr	DON stated the infection rate ne previous month, however mentation to reflect this. A t Infection Control Report, ovided with data entered from une, however, no analysis ding trending or interventions d Surveillance, reviewed veillance as an activity to "find, d prevent nosocomial finition further outlined the llection, analysis of data, ends, passing the information ed to take action and	F	380			

Facility ID: 00019

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		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	6170 11	PRINTED: 12/27/ FORM APPRC <u>OMB NO. 0938-</u>	OVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>′</i>	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
		245278	B. WING		11/28/201	7
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLI	ETION
K 000		rs	КO	000		
~	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ON-SITE REVISIT CONDUCTED TO Y SUBSTANTIAL CO REGULATIONS HA	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST S FORM-2567 WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio the time of this surv Howard Lake was f the requirements for Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 19 Existing	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), 9 Health Care Occupancies.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO: Health Care Fire In State Fire Marshal 445 Minnesota St.,	R THE FIRE SAFETY spections Division				
		DER/SUPPLIER REPRESENTATIVE'S SIG		TITLE	(X6) DAT	TE
	ically Signed		I WILL			2/2017
	, , ,				ling it is determined	44-04

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/27/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245278	B. WING			11/2	8/2017
NAME OF F	PROVIDER OR SUPPLIER			I	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD LAKE		I	OWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa St Paul, MN 55101-	-	K	000			
	Angela.Kappenmar	itney@state.mn.us> and					
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
,	1. A description of v to correct the defici	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date,					
		r title of the person rection and monitoring to ence of the deficiency					
	one-story building v building was constr additions construct	ociety Howard Lake is a with no basement. The original ructed in 1971, with building ed in 1983 and 1994. All ire sprinkler protected and b be of Type II(111)					
	detection in the cor corridors which is n department notifica	re alarm system with smoke ridors and spaces open to the nonitored for automatic fire ition. The facility has a s and had a census of 27 at					

Facility ID: 00019

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION (X3) D	ATE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	. ,		OMPLETED
		245278	B. WING	1	1/28/2017
AME OF F	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S.	AMARITAN SOCIETY	- HOWARD LAKE		413 13TH AVENUE HOWARD LAKE, MN 55349	
(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) COMPLETIOI DATE
K 000	Continued From pa The requirement at NOT MET.	age 2 : 42 CFR, Subpart 483.70(a) is	K 000		
		- Testing and Maintenance	K 345		12/4/17
	A fire alarm system accordance with an with the requirement Electric Code, and and Signaling Code	- Testing and Maintenance is tested and maintained in approved program complying hts of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily and NFPA 25			
	by: Based on docume the Facility failed to Alarm System in ac National Electric Co Fire Alarm and Sign practice could affect Fire Alarm System A fire alarm system accordance with ar with the requirement Electric Code, and and Signaling Code	NT is not met as evidenced Intation review and interview, test and maintain the Fire cordance with NFPA 70, ode, and NFPA 72, National haling Code. The deficient of 27 out of 27 residents. - Testing and Maintenance is tested and maintained in approved program complying hts of NFPA 70, National NFPA 72, National Fire Alarm a. Records of system enance and testing are readily and NFPA 25.		 K345 – Discrepancy in the amount of detectors and switches from the 2016 to the 2017 fire alarm annual inspection. 1. The documentation discrepancies in the number of detectors and switches from the year to year reports has been clarified to reflect the accurate number of devices onsite. 2. Fire Protection company verified this 12/04/2017. 3. The Director of Environmental Service is responsible for this correction and monitoring to prevent a recurrence of th deficiency. 	of on es

Facility ID: 00019

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		& MEDICAID SERVICES			MB NO. 0938-03 (X3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION 01 - MAIN BUILDING 01	COMPLETED	
		245278	B. WING		11/28/2017	
AME OF I	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETI	
K 345	Continued From pa Findings include:	ige 3	K 345			
	11/28/2017, docum there were discrepa detectors, Duct det	veen 9:15 AM and 1:15 PM on entation reviewed revealed ancies in the amount Photo ectors, Heat Detectors and es from the Fire alarm report 2017.				
	This deficient pract Environmental Ser Sprinkler System - CFR(s): NFPA 101		K 353		12/20/1	
	Automatic sprinkled inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available.	Maintenance and Testing and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked				
	b) Who provided	-				
	c) Water system s	supply source				
	any non-required o system. 9.7.5, 9.7.7, 9.7.8,	KS information on coverage for r partial automatic sprinkler and NFPA 25 NT is not met as evidenced				
		of documentation and an it was determined that the		K353 No quarterly sprinkler insp 1. We will resume quarterly testing		

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION		
ID PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A BUILDING	G 01 - MAIN BUILDING 01	001	
		245278	B. WING		11/2	28/2017
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE		
SOOD S	AMARITAN SOCIETY	- HOWARD LAKE		HOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 353	(edition 2012), Spri and Testing Automatic sprinkler inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems information on cove partial automatic sp 9.7.8, and NFPA 25 could cause a dela affecting the safety of staff and visitors Findings Include:	FPA 101 The Life Safety Code nkler System - Maintenance and standpipe systems are and maintained in accordance dard for the Inspection, aining of Water-based Fire S. Provide in REMARKS erage for any non-required or prinkler system. 9.7.5, 9.7.7, 5. This deficient practice y in extinguishing a fire of an undetermined amount	K 35	 Sprinkler Suppression System, semi annual testing. The systema quarterly inspection in Decema fter that, either a semi annual quarterly every quarter as required. Quarterly Inspection was corn 12/20/17. The Director of Environment is responsible for this correction monitoring to prevent a recurred deficiency. 	m will have ber 2017; red. npleted on al Services n and	
	and 1:15 PM on 11 review and staff int	ice was verified by	K 71	2		12/4/17
	signal and simulati conditions. Fire dril times under varying on each shift. The and is aware that d routine. Responsib conducting drills is persons who are q	the transmission of a fire alarm on of emergency fire Is are held at unexpected g conditions, at least quarterly staff is familiar with procedures rills are part of established ility for planning and assigned only to competent ualified to exercise leadership. nducted between 9:00 PM and				

Facility ID: 00019

If continuation sheet Page 5 of 7

		AND HUMAN SERVICES		FORM	12/27/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION (X3) DATE IG 01 - MAIN BUILDING 01 COM	E SURVEY PLETED
		245278	B. WING_	11/2	28/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- HOWARD LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 413 13TH AVENUE HOWARD LAKE, MN 55349	
(X4) ID PREFIX T A G	(EACH DEFICIENC)	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) COMPLETION DATE
К 901	instead of audible a 18.7.1.4 through 18 19.7.1.7 This REQUIREMEN by: Fire drills include the signal and simulatic conditions. Fire drill times under varying on each shift. The s and is aware that d routine. Responsib conducting drills is persons who are que Where drills are co 6:00 AM, a coded a instead of audible a 18.7.1.4 through 18 19.7.1.7 Findings include: During documentat and 1:15 PM on 11 the available fire dr months and intervie Services Director, i failed to complete the night shift in the thi This deficient pract Environmental Services Dur Fundamentals - Bue CFR(s): NFPA 101	announcement may be used alarms. 3.7.1.7, 19.7.1.4 through NT is not met as evidenced he transmission of a fire alarm on of emergency fire Is are held at unexpected g conditions, at least quarterly staff is familiar with procedures rills are part of established lity for planning and assigned only to competent ualified to exercise leadership. nducted between 9:00 PM and announcement may be used alarms. 3.7.1.7, 19.7.1.4 through ion review between 9:15 AM /28/2017, revealed review of ill reports for the last 12 ew with the Environmental t was revealed that the facility he paperwork required for the rd quarter. ice was verified by	K 71	K712 Incomplete paperwork for one fire drill. 1. The missing date on the fire drill paperwork has been entered. Moving forward, fire drill paperwork will be completed promptly and completely after a drill. 2. 12/04/2017. 3. The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency.	12/21/17
FORM CMS-25	567(02-99) Previous Versions			Facility ID: 00019 If continuation she	et Page 6 of

TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245278	B. WING		11/2	28/2017
	PROVIDER OR SUPPLIER	- HOWARD LAKE	4	TREET ADDRESS, CITY, STATE, ZIP CODE 113 13TH AVENUE IOWARD LAKE, MN 55349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
K 901	Categories are dete	ments as detailed in NFPA 99. ermined by a formal and essessment procedure fied personnel.	K 901			
	by: Based on docume interview, the facilit systems are design through 4 requirem Categories are dete documented risk as	NT is not met as evidenced ntation review and staff y failed to inspect the building ned to meet Category 1 ents as detailed in NFPA 99. ermined by a formal and essessment procedure fied personnel. The deficient ct all residents.		K901 Building Risk Assessmen completed 1. The required building Risk Ass NFPA 99 has been completed. 2. It was reviewed and accepted Safety committee on 12/21/2017	sessment by center	
	and 1:15 PM on 11, review and staff inte			3. The Director of Environmenta is responsible for this correction monitoring to prevent a recurren deficiency.	and	
	Environmental Sen	/ices Director.				

Facility ID: 00019

If continuation sheet Page 7 of 7



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 15, 2017

Ms. Laura Salonek, Administrator Good Samaritan Society - Howard Lake 413 13th Avenue Howard Lake, MN 55349

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5278025

Dear Ms. Salonek:

The above facility was surveyed on November 28, 2017 through December 1, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

Good Samaritan Society - Howard Lake December 15, 2017 Page 2 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 Unit Supervisor Brenda Fischer at brenda.fischer@state.mn.us or (320) 223-7338.

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

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

Please feel free to call me with any questions related to this letter.

Sincerely,

Anne Retension -

Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00019	B. WING		12/0	1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh 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	hether a violation has been				
	that may result from orders provided tha the Department with	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 Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health (MDH) tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIC	GNATURE	TITLE		(X6) DATE 12/22/17

Electronically Signed

6899

If continuation sheet 1 of 31

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00019	B. WING		12/	01/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	5349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On 11/28/17 to 12/- Department's staff, the following correc Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far la Tag." The state sta listed in the "Summ column and replace the correction orde the findings which a statute after the sta as evidence by." Fo are the Suggested Time period for Con	1/17, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for ne assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is nary Statement of Deficiencies' es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met pollowing the surveyors findings Method of Correction and				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
			A. BOILDING			
		00019	B. WING		12/01/201	17
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
iood s	AMARITAN SOCIETY		H AVENUE D LAKE, MN	55349		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE CON	(X5) APLET DATE
2 570	MN Rule 4658.040 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570		12/2	29/1
	care must be review interdisciplinary tea physician, a register for the resident, an disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an am that includes the attending ered nurse with responsibility d other appropriate staff in rmined by the resident's needs practicable, with the resident, the resident's legal n representative at least n seven days of the revision of e resident assessment required subpart 3, item B.				
	by: Based on interview facility failed to revi urinary incontinenc	ent is not met as evidenced and document review, the se the care plan to include e for 1 of 1 residents (R6) who urinary incontinence.		corrected		
	Findings include:					
	identified R6 was c limited assistance MDS identified R6	uarterly MDS dated 9/20/17, ognitively intact and required with toileting. Further, the was occasionally incontinent o ven episodes of incontinence).	f			
	self care performar and limited mobility	ed 9/28/17, identified R6 had a nee deficit related to fatigue w. The care plan did not continent of urine as identified				
		11/30/17, at 1:35 p.m. nursing ated that she worked the day	3			

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00019	B. WING		12/	01/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		AVENUE	5349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 570	Continued From pa	ige 3	2 570			
	shift and R6's was when she was work	usually incontinent twice a shift king.				
	nurse (RN)-A stated incontinent of urine	/30/17, at 1:59 p.m. registered d R6 was occasionally and it should have been essed on her care plan.				
	Conferences policy purpose of creating person-centered ca The policy directed reviewed when eac	tre plan" for each resident. the care plan should be h MDS is completed and care sed as the resident's				
	The director of nurs inservice staff rega is updated for accu DON or designee c	THOD OF CORRECTION: sing (DON) or designee could rding ensuring the plan of care racy in a timely manner. The ould audit to ensure ongoing port the audit results to the at group.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and e; General	2 830			12/29/17
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a				

L51311

If continuation sheet 4 of 31

Minnesc	ta Department of He	ealth			FORM APPROVEI
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00019	B. WING		12/01/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		I AVENUE LAKE, MN	55349	
(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 COMPLETE
2 830	Continued From pa	age 4	2 830		
		he attending physician that the ain in bed or the resident a bed.			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide adequate supervision and safety with unsupervised smoking for 1 of 1 residents (R8) identified to have cigarette burns on their clothing and skin. This resulted in an immediate jeopardy (IJ) situation for R8 who remained at risk for burns and serious injury with unsupervised smoking.			corrected	
	R8 had sustained r burns to his clothin smoking. Although knowledge of these addressed and R8 reassessed and int provide adequate s unsupervised smok p.m. the director of environmental serv IJ for R8. The IJ w 2:19 p.m., however an isolated scope a	/28/17, when it was identified epeated incidents of cigarette g and skin from unsupervised direct care staff had e incidents, they had not been was not comprehensively erventions developed to safety with independent, king. On 11/29/17, at 5:06 nursing (DON) and director of ices (DES) were notified of the as removed on 12/1/17, at r, non-compliance remained at and severity which indicated no otential for more than minimal			
	Findings include:				
		um Data Set (MDS) dated			
linnesota D TATE FOR	epartment of Health M		6899	L51311	If continuation sheet 5 of 3

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00019	B. WING		12/	01/2017
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		HAVENUE DLAKE, MN 5	5349		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
2 830	Continued From pa	age 5	2 830			
	9/13/17, identified I	R8 had intact cognition,				
		ehavioral symptoms (i.e.				
	, , ,	d did not display any episodes				
		. R8's medical diagnoses				
		gia (paralysis of all four limbs)				
		ess. Further, R8 required ce with activities of daily living				
		ance from staff for transfers,				
		tobacco products, however,				
		ears, burns (2nd or 3rd				
		ben lesions on his skin.				
		cal Diagnosis listing printed				
		R8 had a history of muscle				
	spasms and contra	acture of the muscle(s)				
		lening of the muscles, tendons				
		en leading to deformity or				
	rigidity of a joint) to	an unspecified site.				
		d Tobacco Use Assessment				
		tified R8 currently used				
		ed over 10 times a day during ing, afternoon, night) with no				
		was able to make decisions				
	regarding daily life					
		ision impairment(s), however,				
		concerns which, "would affect				
		oke or use tobacco products"				
		sessment. The assessment				
		at R8's identified dexterity				
	concerns were, nor	r any information on how they				
		d. R8 displayed no physical				
		ould interfere with their ability				
		ack in the center. The				
		a section labeled, "Safety,"				
		was able to light his own				
		ained a question of, "Resident				
		equipment," along with several				
		Icluding a smoking apron,				
		pervision, one to one of the above,"				
	epartment of Health					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00019	B. WING		12/	01/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY		HAVENUE DLAKE, MN 5	5349		
(X4) ID		TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	R8 had no history of cigarette, falling as himself or clothing, tobacco-related bel assessment lacked location for R8's sm cigarette or ash dur attempted intervent or unsuccessful for R8's care plan print bilateral hand contr injury along with lim to quadriplegia. R8 without staff assista device, and demon	her, the assessment identified or incidents with dropping the leep while smoking, burning or other unacceptable havior(s) in the past. The d any information on physical noking, his ability to hold a ring use, or any history of tions which had been refused r R8. ted 11/29/17, identified R8 had ractures due to a spinal cord nited physical mobility related 8 was unable to transfer ance and a mechanical lift istrated potential mood h notation he, "easily angers				
	towards staff." Fur R8 used tobacco pulisted a goal of, "[R products in designa burns." The only in this goal was identi tobacco use, cigare on my wheelchair a plan lacked any fur	ther, the care plan identified roducts off facility grounds and 8] will safely use tobacco ated area. I will be free from itervention listed to help meet fied as, "I am independent with ettes and lighter are in a pouch and always with me." The care ther information, including any ised interventions, pertaining to				
	smoke. R8 wheele electric wheelchair hallway. R8 had vis fingers on both han himself past the rec of the facility and di	8 p.m. R8 was observed to ed himself out of his room in an and proceeded down the sible contractures of his ids. R8 proceeded to wheel ception desk in the main lobby id not sign himself out of the				
	down to the end of	ng the nursing home and going the driveway, however, he ursing home property. R8				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00019	B. WING		12/	01/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	55349		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET
2 830	Continued From pa	age 7	2 830			
	his gray colored ho and turned it upside	d package of cigarettes from oded sweatshirt front pocket e down on his lap exposing a dard lighter with a plastic body neel.				
	pointer finger and p rest of his fingers b towards his palm(s to light the cigarette however, was unab R8 stated he had, ' his cigarettes in the mouth. R8 then us cigarette with his th remaining fingers v towards the palm. hold the lighter. R8 abdomen with both several times with being held immedia he attempted to lighter.	igarette using his thumb and blaced it into his mouth, the being contacted inwards b). R8 attempted several times e in his mouth using the lighter ble to after several attempts. "lots of years practice," lighting e wind and removed it from his sed his right hand to hold the humb and first finger as the vere contracted inwards R8 used his opposite hand to 8 then pressed into his hands while flicking the lighter visible sparks and open flame ately next to his sweatshirt as ht the cigarette and bring it to he cigarette and used his right his mouth.	,			
	going outside on hi hour and a half or s himself before whil "cigarette cherry [re cigarette]" will fall o his skin due to poo downward. R8 stat	tes several times a day often is own to smoke, "once every so." R8 stated he has burned e smoking as ash or the ed hot ash on the end of the lit off and he is unable to feel it on r sensation from his shoulders ted he last burned himself a r and showed the surveyor a				
	surrounded by light aspect of his first fi area was approxim	colored scabbed area t pink colored skin on the inner nger of his right hand. The nately 0.5 centimeters (cm) in dded he had sustained burns,				

STATEMEN	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00019	B. WING		12/	01/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	5349				
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
2 830	just like the one he R8 then lifted up hi showed a visible, a diameter, hole in th the sweatshirt. R8 ash which had falle R8 stated none of t about his smoking, him while he smok about a smoking a "heck no." R8 state complication or pot	e showed, before. In addition, s gray colored sweatshirt and upproximately 2.5 cm in he center of the front side of stated it was from a cigarette en on it from awhile prior. the staff had spoken to him , nor do they come outside with es, however, when questioned pron being used he replied, ed if he were to have a tentially start his clothing on						
	nursing home and smoking his cigare from his mouth usi the remaining filter did not extinguish t of it. R8's most recently V2 dated 11/21/17, pressure ulcer on h	his cell phone to call the ask for help. R8 finished tte at 2:08 p.m. and removed it ng his right hand and tossed and butt into the street. R8 he cigarette before disposing completed Skin Observation - identified R8 had a chronic his gluteal fold(s), however ed burns or skin injuries on his	t					
	When interviewed nursing assistant (I smoke after he get typically "gone a fe stated she had new outside to observe had noticed burn h The most recent bu jacket, however, N these were old or r owned the coat for R8 was independe	on 11/28/17, at 2:24 p.m. NA)-A stated R8 goes out to is up for the day and then is w hours" around town. NA-A ver personally helped or gone R8 while smoking, however, oles in his clothing before. urn holes being on his winter A-A stated she was not sure if new burn holes though as he awhile. Further, NA-A stated nt with his smoking and staff or did R8 wear or use any						

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED			
		00019	B. WING		12/	01/2017			
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE					
GOOD S	AMARITAN SOCIETY		HAVENUE DLAKE. MN §	55349					
(X4) ID									
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	COMPLET DATE			
2 830	Continued From pa	age 9	2 830						
	adaptive devices w knowledge.	hile smoking to her							
	"not supposed to," wanted to smoke w they had to be able assistance because NA-B stated she ha burns on his hands hot and creates a b "every couple mont observed a burn or three months prior motion on his hand always notice them had reported these however, was unab had been reported the surveyor and N to observe his burn check for additional left the facility and w	independently and staff were, help him as if a resident while living at the nursing home to do it without staff e, "That's just the policy here." ad noticed R8 to have cigarette before because it "gets too olister," adding this happened ths." NA-B stated she last n R8's hand approximately when completing range of l(s) further adding, "that's how the burns to the nurse(s), ole to recall anyone specific it to. On 11/28/17, at 2:34 p.m. IA-B attempted to visit with R8 n and go through his clothing to al burn holes, however, R8 had was not available.							
	personal laundry fo smoked adding his functional." LA-A s burn holes in his clu she doesn't "look a	ated she completed all or R8 and was aware he hands "aren't 100 percent tated she had never noticed othing before, however, added t them that close." LA-A ed several pieces of clothing							
	which had been ha room. R8 had a pla several holes in the these were "wear h the gray colored sw	nging on a rack in the laundry ain green colored shirt with front. LA-A stated she felt noles" though. LA-A removed veatshirt R8 had worn the day							
innesota D		ed to smoke by the surveyor, A-A verified a hole in the front							

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00019	B. WING		12/	01/2017		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY		HAVENUE DLAKE, MN 5	5349				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
2 830	Continued From pa	age 10	2 830					
	a cigarette burn." F currently was not in completing his laur should be checking When interviewed of trained medication smoker and goes " property" to smoke TMA-A stated R8 w and was able to sa lighter without assis of any burns on R8 stated staff should charge nurse and of (an 'early warning t identified while cari stated she "would a the cigarette and/or was smoking as R8 himself when smok out using a paper lo smoke. TMA-A sho which identified sev failed to sign himse he returned. TMA- stated R8 "should to record as "he's bee TMA-A stated staff he returned from sn around town. An undated, blank Warning Tool" was instructions to com identified a change resident," then to p follow-up. Some est	nd stated, "I would say that was Further, LA-A stated she hspecting R8's clothing when hdry, however, added "I guess I g [his] clothes better." on 11/29/17, at 9:33 a.m. aide (TMA)-A stated R8 was a down to the end of the after he gets up for the day. vas independent with smoking fely use cigarettes and a stance. TMA-A was unaware 's skin or clothing, however, "report it right away" to the complete an Stop-and-Watch ool' used when a change is ng for a resident). TMA-A assume" R8 would just put out r fire, if one occurred, while he 8 took "full responsibility" for ting. R8 was to check in and og when going outside to owed this log to the surveyor veral empty spaces when R8 elf back into the facility when A reviewed the record and be" filling out the sign in/out en told to" use it. Further, did not inspect R8's skin when moking or from his outings "Stop and Watch Early provided. The form listed plete one when, "you have while caring for or observing a rovide the form to a nurse for xamples provided on the form ncluded, "Seems different than						

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			01/2017
	AMARITAN SOCIETY	413 13T	H AVENUE			
		HOWARI	D LAKE, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	R8's medical recor	usual," and, "Change in skin color or condition." R8's medical record lacked any evidence one of these had been completed for any burns in his				
	progress note date smoke and did not time further adding risk/benefit of all ec makes." The note what information re been provided, nor	d was reviewed. A handwritter d 4/16/13, identified R8 to want to pursue quitting at the him to, "understands ducation and choices that he lacked any information on elated to safe smoking had what interventions, if any, d/or refused to ensure safe king.				
	identified R8 "conti cigarettes independ lighter at all times." observation, asses	ress note dated 6/21/17, nues to be safe to smoke his dently and hold them and the ' The note lacked any sment or dictation to describe tion had been made of R8's king abilities.				
	through 11/21/17 (in reviewed and ident physician a total of period. R8 was ide on each of the visit identified as having remain on Valium (anxiety and muscle spasms". All of the	gress note(s) dated 2/14/17, most recent visit), were ified R8 had been seen by his seven times in the 10 month entified as a "current smoker" is. On 2/14/17, R8 was g quadriplegia and needed to medication used to treat e spasms) "for control of e provided notes lacked any smoking related injuries or his king abilities.				
	reassessment of R	al record lacked any identified 8's unsupervised smoking taining burns on clothing and				

	ta Department of He				1	APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		01/2017
	AMARITAN SOCIETY	413 13TI	H AVENUE			
3000 3	AMANITAN SOCIETT	HOWARD	DLAKE, MN 5	5349		-1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	occupational thera smoking; nor evide	skin described by NA-A and NA-B; any history of occupational therapy (OT) interventions for his smoking; nor evidence of other attempted interventions to promote safety with unsupervised smoking.				
	In addition, the record lacked any documented or recorded incident report(s) related to the cigarette burns sustained on his clothing and skin as described by NA-A and NA-B, nor any evidence the facility had attempted to provide on-going collaboration with R8 to develop and implement interventions or therapies related to his unsupervised smoking. The facility provided no additional notes or medical record entries regarding these items during the survey.					
	stated she was aw was the "first thing gets up." R8 was i and when he leave for himself then." I been told of any bu before; nor had she smoking apron bef a nice thing to have	n 11/29/17, at 12:47 p.m. NA-E are R8 smoked and added it he does when he goes and ndependent with his smoking is to smoke, he "is responsible NA-E had never noticed or urns on R8's skin or clothing e ever seen him wear a ore, however, felt it would "be e" as R8 was not someone to e dropping the cigarette or the staff.				
	NA-F stated staff " smoking. R8 goes street and, "whatev building, we don't k staff were not com	on 11/29/17, at 12:54 p.m. don't help him [R8]" with outside and smokes on the ver happens outside of this now it." Further, NA-F stated pleting any formal skin checks ns upon his return, but merely as it?"				
		03 p.m. registered nurse				
nesota D ATE FORI	epartment of Health M		6899	51311	If continuation	on sheet 13 c

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00019	B. WING		12/	01/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		HAVENUE DLAKE, MN 5	55349		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 13	2 830			
	quadriplegic, had p fingers on both han himself out of the b smoke as he was u grounds. RN-C wa R8's clothing or ski smoking as "nothin if staff are noticing it should be reporte so the physician ca report can be comp R8 was independen lighter, however, ac him smoke persona had been assessed before the survey.	ewed and identified R8 was a oor sensation and contracted ids and was supposed to sign uilding each time he wanted to inable to smoke on facility is unaware of any burns on in resulted from cigarette g got reported." RN-C stated burns on his clothing and skin, ed to the nurses immediately in be updated and an incident oleted. Further, RN-C stated int with using his cigarettes and dded she had never watched ally nor was she aware how he d to be safe with smoking				
	stated she had wor approximately two smoked "since he of years prior. R8 typ and then "does his as he is unable to s grounds, however, just go down to the smoke in the later of she "would assume been done on adm not sure adding she safe unsupervised she was unaware F cigarette burns on I not been reported t until now. RN-B sta ever been consulte R8's unsupervised	11/29/17, at 1:27 p.m. RN-B ked at the facility for and a half years and R8 had came" to the nursing home ically gets assisted out of bed own thing in the community" smoke on the campus RN-B added at times R8 will end of the driveway and evening hours. RN-B stated e" a smoking assessment had ission for R8, however, was e had never assessed him with smoking before. RN-B stated R8 had been sustaining his clothing and skin as it had o her or raised as a concern ated she did not think OT had d in the past to help address smoking adding, "not since urther, RN-B stated R8 burning				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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		00019			12/	01/2017
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GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	5349		
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TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
2 830	Continued From pa	age 14	2 830			
	should do somethir "we got to be keepi	ng right now" to help him as ng him safe."				
	stated she was awa however, added sh location(s) he was a don't feel like I'm hi person" when he le was unaware R8 ha his hand, nor was a being observed in h with R8's paralysis contributed that he, burning his skin or	on 11/29/17, at 1:55 p.m. RN-E are R8 goes outside to smoke, e did not know the physical smoking when outside as, "I is babysitter." R8 was "his fit the facility. RN-D stated she ad a current cigarette burn on she aware he had burn holes his clothing by staff. RN-D felt and poor sensation , "might not know its [cigarette clothes] happening," and NA porting those things to nursing	•			
	safety." On 11/29/17, at 2:1 nursing (ADON) wa she had worked at four years and R8 h time. R8 was last a smoking in Septem	5 p.m. the assistant director of as interviewed. ADON stated the nursing home for nearly nad smoked during that entire assessed by ADON for lber 2016 (assessment dated elt he was safe at the time.				
	ADON stated R8 "u everything" includin however, she was u cigarette in 2016 w ADON stated she v burning his clothes adding the NA staff	uses his thumbs a lot with ag lighting his cigarettes, unable to recall how R8 lit the hen she last assessed him. vas unaware R8 had been and skin with his cigarettes had never reported those the NA staff identify a new				
	concern with a residual clothing and/or on tool should have be addressed and R8 safety with smoking	dent, like cigarette burns in their skin, a stop-and-watch een completed so it could be could be reassessed for his g. Further, ADON stated she rone had discussed the risk of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		00019	B. WING		12/	2/01/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	12/01/201			
GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	5349				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
2 830	Continued From pa	age 15	2 830					
		had OT ever been consulted erventions to ensure R8 was pervised smoking.						
	Reference Guide d which identified it h prior to survey. Th assessments along when to complete t Assessment was lis completed by a reg " on admission fo products; required use tobacco produc completed; or when ability, judgment, m mobility." Further, assessment should	ser defined assessments) ated 12/1/17, was provided ad been in use at the facility ne guide listed several g with their use, purpose and hem. The Tobacco Use sted which should be istered nurse or social worker, or residents who use tobacco for all residents who smoke or cts when not previously in there is a change in cognitive nanual dexterity, and/or the guide directed the d be completed when an and listed, "smoking injury" as)					
	stated she was new unaware of the faci regarding having a completed. OT-A r and stated there wa consulted for R8 fo however, OT-A stat compensatory metl R8 did not have us his cigarettes and p his clothing on fire; cognition, looking a skills while using a comprehensive ass sensation and OT-r even know he's bei	a 11/29/17, at 2:28 p.m. OT-A v to the nursing home and lity's policies and procedures smoking safety assessment reviewed the therapy record as no history of OT being r his unsupervised smoking, ted there were definitely "some hods" which could be used so e his abdomen or chest to light potentially burn himself or start including assessing his at his dexterity and handling cigarette and "just do a sessment." R8 had impaired A questioned, "Does he [R8] ing burned?" Further, OT-A with impaired dexterity and	t					

STATEMEN	T OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA	(X2) MHHTIPI F	CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00019	B. WING		12/	01/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	5349		
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2 830	Continued From pa	ge 16	2 830			
	unsupervised smok	w them so as to "assess				
	(DON) was interview unsupervised smoke working at the nurs her knowledge R8 H interventions from s "his own person and well pleases," and H things, then being u day and yelling at th interventions offere smoking were done and they just had no stated she was una himself while smoke reported, however, burns in his clothing have completed a S could be treated an Further, DON state responsible to ensu- when he signs hims own person. During 11/29/17, at 5:06 p. made to the State a potential neglect for	5 p.m. the director of nursing wed regarding R8's sing. DON stated she started ing home in June 2017, and to had always refused staff for his smoking. R8 was d will do whatever he dang had a history of telling the staff upset about them the following hem. DON stated the d to him in the past with his e as in passing conversations of been documented. DON ware R8 had been burning ing as it had not been if NA staff noticed cigarette g or on his skin, they should Stop-and-Watch so the burns d staff "can be looking at it." d the facility was ultimately ure R8 was safe, however, self out and leaves, he was his g a follow up interview on m. DON stated a report was agency (SA) regarding r R8 since he had been e burns from unsupervised				
	3/2016, identified it smoking inside Goo buildings was not p	ee Locations policy dated applied to skilled care and od Samaritan Society (GSS) ermitted. The policy directed, s who smoke or use tobacco				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00019	B. WING		12/	01/2017
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	• • • •	
GOOD S	AMARITAN SOCIETY					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	HOWARI ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D LAKE, MN 5	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	designate acceptat resident smoking w for staff member of residents who use Use Assessment of assessments would has a change in co dexterity or mobility direction or proced how to address cig and/or skin, should A Smoking and Tok identified it applied purpose of reaffirm safe and healthy er residents and visito smoking shall be d entrance of the fac "readily visible" to s smoke must not po themselves or othe direction or proced how to address saf	d staff members would ble outdoor locations for which "must be readily visible oservation." Upon admission, tobacco will have a Tobacco ompleted. Further, additional d be completed if a resident gnition, judgment, manual w. The policy lacked any ure for staff to implement on arette burn(s) on clothing they occur. bacco Use policy dated 4/2017 to skilled care and listed a ing the GSS commitment to "a nvironment for employees, ors." The policy directed one away from the main ility in spaces which were staff. Further, "Residents who use a safety hazard to ors." The policy lacked any ure for staff to implement on ety with smoking nor cigarette and/or skin, should they	L			
		or procedures related to unsupervised smoking were				
	12/1/17, at 2:19 p.r	n on 11/28/17, was removed or n. after the facility successfully noval plan which included the				
	smoking which ider	ed by nursing for unsupervised ntified he required a smoking Ider, supervision and one on				
	T OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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		00019	B. WING		12/	01/2017
AME OF P	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		01/2017
	AMARITAN SOCIETY	413 13T	H AVENUE			
1000 5/	AMARITAN SOCIETY	- HOWARD LAKE HOWARI	D LAKE, MN 5	5349		
(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 AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 18	2 830			
	one assistance. Reinterventions, howe evaluation for safet identified R8 to now related incidents in incident of burning report as it was "no progress note for F dated 11/29/17, at a ADON. ADON exp the burn(s) for pote demonstrated how as reporting he had observed by the su have gotten a differ with the shitty one a - An OT consultation assess and develop unsupervised smol Treatment Note da having an "incompl C5 - C7 [vertebrae] sensation, impaired impaired motor cor evaluation which id the lighter away fro thumb still very nea need to further exp burn." Further, R8 plastic-smoking ad with throwing out th hot end nears hand - Educating all staff on clothing and/or s	B refused all of these ever, R8 "agreed to [OT y]." Further, the assessment v have a history of smoking cluding "a self reported his finger" which he failed to ot a big deal." A subsequent 88's smoking reassessment 6:45 p.m. was authored by blained to R8 they had reported ential neglect of care while R8 he smoked. R8 was identified a "shitty lighter" when rveyor on 11/28/17, and should rent one, "instead of fighting and almost burning my shirt." on was made for R8 to screen, p interventions for safe, king. A provided OT Daily ted 12/1/17, identified R8 as ete SCI [spinal cord injury] at]," who had impaired d upper body strength and htrol. OT completed a smoking entified R8 was able to strike m his body, however, "[his] ar flame when lighting. Will lore options to reduce risk of a agreed to trying a aptor and e-cigarettes, along he cigarette mid-way "before				
	and documented. On 12/1/17, from 2	:01 p.m. to 2:18 p.m. nursing				
		ff were interviewed to ensure				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		00019	B. WING		12/	01/2017
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	5349		
(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	TION SHOULD BE	(X5) COMPLET DATE
2 830	unsupervised smol	orovided related to R8's king including ensuring R8's	2 830			
	potential burn injuri tool and communic	as routinely monitored for es, use of the Stop-and-Watch ating changes in resident and documentation standards nge in condition.	1			
	The director of nurs review and revise a smoking assessme policies/procedures DON or designee of	s and educate all staf. The could audit to ensure ongoing port the audit results to the				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 910	MN Rule 4658.052 Incontinence	5 Subp. 5 A.B Rehab -	2 910			12/29/1
	have a continuous management to rec unnecessary use o comprehensive res home must ensure A. a resident w without an indwellir unless the resident that catheterization B. a resident w receives appropriat prevent urinary trac	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: tho enters a nursing home ng catheter is not catheterized 's clinical condition indicates was necessary; and ho is incontinent of bladder te treatment and services to ct infections and to restore as ler function as possible.				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00019	B. WING		12/	12/01/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN	55349			
(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 IE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 20	2 910				
	by: Based on observat review the facility fa	ent is not met as evidenced ion, interview and document ailed to comprehensively sidents (R6) with a change in		corrected			
	Findings include:						
	6/21/17, indicated s hypertension and d further indicated sh urine and was not o quarterly MDS date now occasionally ir on a toileting progra assessment (CAA) had urinary urgenc toileting. The CAA	mum Data Set (MDS) dated she was cognitively intact, had liabetes mellitus. The MDS he was always continent of on a toileting program. R6's ed 9/20/17, indicated she was nocontinent of urine and was not am. R6's care area dated 3/29/17, indicated she y and need for assist with indicated she received of indicate she was incontinent.					
	hypertension, type heart failure. The c activity of self care	ed 9/28/17, indicated she had two diabetes and congestive are plan indicated she had performance deficit related to mobility. The care plan did not icontinent of urine.					
	dated 10/2/16, india than daily with a ma absorbent pad. The denied incontinenc trouble with it. R6 c episodes documen 9/28/16. There we	tinence Data Collection tool cated she was wet less often edium amount and she wore a e tool further indicated R6 e and could not recall having could not recall the two ted since admission on ere no further assessments dder incontinence. R6's Skin					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00019	B. WING		12/	01/2017
	PROVIDER OR SUPPLIER	- HOWARD LAKE 413 13T	DDRESS, CITY, S H AVENUE D LAKE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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) COMPLE DATE
	excoriation to her ri R6's Point of Care incontinence for the	11/24/17, indicated she had ght and left buttocks. (POC) response history for a last 30 days indicated she urine 10 times in November.				
	(LPN)- A and certifi were observed to p was continent of ur in the toilet. LPN-A	0 a.m. licensed practical nurse ed nursing assistant (CNA)- C lace R6 onto the toilet. She ine and voided a small amount was observed to clean R6's ed area that covered most of uttock.				
	worked the day shi	5 p.m. CNA-C stated that she it and R6 was usually shift when she worked.				
	(RN)-A stated R6 d assessment after h urine to occasional stated the facility w they needed to wor performance impro they wanted more n urine. RN-A further program assessment for quarterly bladder missed. In addition	9 p.m. Registered Nurse id not receive a bladder er change from continent of y incontinent of urine. RN-A as aware this was an area k on and it was part of their vement project. RN-A stated esidents to be continent of r stated currently the computer int tool did not provide an alert r assessments so they were n RN-A stated they were only ry of incontinence going back hursing assistant				
	stated that when sh usually continent of					
nesota Di	Although R6 had a epartment of Health	change in urinary incontinence	;			<u> </u>

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00019	B. WING		12/	12/01/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
OOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	5349			
(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 AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 22	2 910				
	the facility failed to minimize the risk o	reassess the incontinence to further change.					
	3/17, indicated the bladder patterns, in identify potentially n incontinence and to urinary incontinence programs. The Ass be done quarterly a should be individual modified as approp assessment/evaluat to the interventions	ation of the residents response					
	The director of nurse ensure policies and updated for resider designee could edu DON or designee could	THOD OF CORRECTION: sing (DON) or designee could d procedures are reviewed and nt toileting needs. The DON or ucate all appropriate staff. The could audit to ensure ongoing port the audit results to the nt group.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21390	Subp. 4. Policies control program m procedures which p A. surveillance collection to identify	0 Subp. 4 A-I Infection Control and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in				12/29/1	
		r detection, investigation, and s of infectious diseases;					

If continuation sheet 23 of 31

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00019	B. WING		12/	01/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- HOWARD I AKE	HAVENUE LAKE, MN	55349		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLET DATE
21390	Continued From par	ge 23	21390			
	reduce risk of trans D. in-service ec prevention and cont E. a resident he immunization progra defined in part 465 procedures of resid the prevention and F. the developm employee health po practices, including defined in part 4658 G. a system for H. a system for products which affe disinfectants, antise incontinence produc	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; nent and implementation of licies and infection control a tuberculosis program as 8.0815; r reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and				
	by: Based on observation review the facility factom comprehensive infection included data analyst trending to reduce to to other residents in potential to affect all the facility. Findings include: The facility's infection from June 2017, the The facility provided Report of Resident	ent is not met as evidenced on, interview and record iled to develop a ection control program which sis of resident infections and he risk of spread of infections the facility. This had the I 27 residents who resided in on control logs were reviewed rough November 29, 2017. d a document, titled Monthly Infections In Center, with a oth and year. The headings		corrected		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00019	B. WING		12/	12/01/2017	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		01/2017	
300D S	AMARITAN SOCIETY		H AVENUE				
		HOWARI	DLAKE, MN 5		0000000101		
(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 AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE	
21390	Continued From pa	age 24	21390				
	infections, the num acquired (nosocom community acquire included the followin number, date admini infection, culture ta agent, antibiotic tre- isolation (yes or no no). This document designations for sy antibiotics or non-boor fungal infections The facility also pro Review Report, as titled monthly infect summary included types, and identifier nosocomial or com	mptoms not treated with pacterial infections such as vira by ded documents titled Data s well as a summary document tion control report. The a breakdown of infection d whether the infection was munity acquired. Hand written m of the form were titled					
		ogs identified the following:					
	Infections in Cente six residents were total of 10 courses categories of infect infections as follow	d Monthly Report of Resident r, dated June of 2017 identified treated with antibiotics for a of antibiotic therapy. The tion included the breakdown of rs: Prophylactic antibiotic use - strointestinal (clostridium					
	difficile - c. diff. a h which may cause of respiratory/lung info infections - two res in one resident. A	ighly infectious bacterial illness liarrhea) - one resident; ections - three residents; skin idents; and a urinary infection document titled Order Listing					
inesota D	who had received a	e 28, 2017, identified residents antibiotics, antifungal's, onth of June. Although					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00019	B. WING			01/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	5349		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390		ige 25 tiviral's were noted on the	21390			
	were listed on the r Monthly Infection C of one nosocomial acquired infections infections, yet six re the document. A h titled Trends, identi continued infection 2017), and identifier reflect a "Downwar not included to ider pattern identified. T education on aspira copy learning as we and skin/soft tissue requested, a Data I provided for 6/17.	esidents receiving antibiotics eport of infections. The control Report identified a total infection and four community , to total five identified esidents were addressed on and written narrative note, fied the presence of one from the previous month (May d the number of infections d trend". Additional data was htify the previous trends or any the action plan identified staff ation pneumonia with hard ell as urinary tract infections, e education. Although Review Report was not				
	four residents were total of four courses categories of infect respiratory/lung infe infections - one res one resident. The M Report identified a infection, and two c	t dated July of 2017, identified treated with antibiotics for a s of antibiotic therapy. The ion included the following: ections - three residents; skin ident; and a urinary infection in Monthly Infection Control total of one nosocomial community acquired infections. ative note titled Trends,	1			
	identified a resolver admission, with ide However, the reside antibiotic use. One skin/soft tissue hea initial log reflected i implemented for tree	d urinary tract infection upon ntified negative lab work. ent continued on prophylactic incident was identified as ling without antibiotics. The ntravenous antibiotics were eatment. The action plan cation on handwashing and				

TATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
IND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		00019	B. WING		12/	01/2017
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H AVENUE D LAKE, MN 5	5349		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
21390	Continued From pa	ge 26	21390			
		positive findings identified				
	tract infection, whic	eated for an upper respiratory h was nosocomial. The				
		isolated to one resident. The ally noted attempts to				
		ic therapy for a resident on a				
	prophylactic antibio	tic were successful. Although				
		d the data trending was rovide a comparison to				
		r did it identify a goal for the				
		goal was "to be determined".				
		cated the information had beer	1			
		ovement) group on 8/25/17,				
	and no action was	taken.				
		ugust 2017 identified three				
		ted with antibiotics for a total antibiotic therapy. One				
		in each of the following				
	categories: respirat	ory/lung infection, skin				
		ointestinal. A document, titled rt, dated 8/15/17, identified				
		dent being treated with				
	antibiotic therapy th	rough 8/18/17, and three				
		eated with an antifungal				
		Listing Report dated 9/1/17, ional resident was treated with				
		and one resident continued to				
		reatment. The Monthly				
		eport identified a total of two ns, and one community				
		A hand written narrative note,				
	titled Trends, ident	ified three infections of				
		vith no trends noted. The note				
		le of bronchitis was isolated infection. The action plan				
	-	ducation on isolation				
		to recurrent problems with c.				
	ditt. A Data Review	Report was provided for the				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00010	B. WING				
		00019			12/01/2017		
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ H AVENUE	TATE, ZIP CODE			
OOD S	AMARITAN SOCIETY		D LAKE, MN 5	5349			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	COMPLET DATE	
				DEFICIENC	() ()		
21390	Continued From pa	age 27	21390				
		positive findings identified one	•				
		d for upper respiratory tract					
		s nosocomial, which remained					
		dent. The negative findings tic antibiotic treatment with risk					
		ement noted. It was also noted					
		positive culture will always tes					
		review identified trending was	-				
		nparisons were provided. The					
		continued to indicate it was					
		ed". Although the review					
		rending was positive, it did not					
		on to previous trends, nor did					
		the data measure. The					
		ted to have been reviewed by 9/20/17 with no action taken.					
	the QAFT group on	9/20/17 WITTIO action taken.					
	The Monthly Repor	t for September of 2017					
		sidents were treated with					
		al of eight courses of antibiotic					
		ew of the entries, it was noted					
		8/26/17. The categories of					
		he breakdown of infections as					
		ons - two residents, urinary					
		idents, and c. diff. in one					
		listing report, dated 10/18/17,					
		ose receiving antibiotic and The Monthly Infection Control					
		total of three nosocomial					
		community acquired					
		written narrative note, titled					
		trends were noted. A					
	,	nade identifying the c. diff.					
	infection was isolat	ed. It was noted three of five of	f				
	-	ections were community					
		nosocomial, and one was					
		nit." The action plan identified					
		round, assessment,					
		SBAR)" notification was					
	provided to priysicia	ans, staff educated and				1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COM		
		00019	B. WING	B. WING		01/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		HAVENUE DLAKE, MN 5	5349			
(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 AC CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLET DATE	
ind			in la	DEFICIENC			
21390	Continued From pa	age 28	21390				
	interventions implemented. A note was written to monitor hand hygiene, however, it did identify how this would be done. A Data Review Report was requested but not provided for the month of 9/17.		,				
	the center identified courses of antibioti infection included the follows: respiratory, gastrointestinal/colu- listing report, dated those receiving ant The Monthly Infecti- total of two nosoco community acquire narrative note, titled were noted. The ac- [influenza]/pneumo- noting reeducation precautions/vaccina- was provided for the noted a positive da the facility goal was information was no	report of resident infections in d three residents with four c therapy. The categories of he breakdown of infections as /lung - two residents, and on - two residents. An order I 11/13/17, was provided for ibiotic and antifungal therapy. on Control Report identified a mial infections, and one d infections. A hand written d Trends, identified no trends ction plan identified "flu nia season approaching, was provided on ations." A Data Review Report e month of October, 2017, and ta trending direction, however, s yet to be determined. The ted to have been reviewed by 11/17/17, and no action was					
	in the center identifiname and first initial additional documer sticky notes there whave received antike dates; 11/12/17, 11 11/27/17. There we provided when the was initially reviewed	7, report of resident infections ried one resident, with only first al of the last name, with no hts provided. On three pink were four residents identified to piotic therapy on the following /17/17, 11/17/17, and ere no additional documents Infection Control Log book ed 11/28/17. Although hthly Infection Control Report					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00019	B. WING	B. WING		12/01/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	, . <u> </u>		
GOOD S	AMARITAN SOCIETY	413 13T	H AVENUE				
	1	HOWARI	D LAKE, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21390	Continued From pa	age 29	21390				
	11/17.						
	director of nursing regarding infections admitting to the factor received. The DON was monitored through the information on compiled monthly. regarding current in Communication Bot the DON further stat to day as it was used trending. In reviewing the DON stated states provided for handwing identified an increas tract infections in 9 monitored for ongot through observatio UTI's was identified demonstrations of implemented. The was compared to the there was no documentable titled Resident dated 2017 was pro- January thorough of was provided regar- implemented. A facility policy, titlet 10/17 identified sur- analyze, control an infections." The de- process as date co- establishment of the communication of the communication of the communication of the communication of the communication of the communication of the communication of the communication of the communication of the communication of the communication of the communi	bok and shift reports. However, ated the log was not used day ed for monthly tracking and ing training needs identified, aff education had been vashing in 7/17. The DON ise in prevalence of urinary /17. The DON stated staff was bing handwashing techniques n. Although an increase in d, audits and/or return handwashing had not been DON stated the infection rate he previous month, however mentation to reflect this. A bit Infection Control Report, ovided with data entered from June, however, no analysis rding trending or interventions ed Surveillance, reviewed rveillance as an activity to "find d prevent nosocomial efinition further outlined the ollection, analysis of data, rends, passing the information and to take action and					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 12/01/2017		
		00019					
			L DDRESS, CITY, STATE, ZIP CODE			12/01/2011	
iOOD S	AMARITAN SOCIETY	- HOWARD LAKE 413 13T	H AVENUE				
(X4) ID	SUMMARY STA		D LAKE, MN 5	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE		
21390	Continued From pa	age 30	21390				
	The director of nurs review and revise a policies and procect comprehensive sur facility wide infection includes time, com trending. The direct designee could edu director of nursing develop auditing sy compliance with inf procedures and rep improvement group	rveillance and analysis of on control systems which prehensive tracking and tor of nursing (DON) or ucate all appropriate staff. The (DON) or designee could rstems to ensure ongoing fection control policies and port those results to the quality					