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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LGOE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00969

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245249**
2.STATE VENDOR OR MEDICAID NO.
(L2) **050318500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW**
(L4) **515 FRANKLIN STREET SOUTH**
(L5) **GLENWOOD, MN** (L6) **56334**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/03/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/30

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B for both health and life safety code. Effective April 3, 2013, the facility is certified for 32 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Miriam Thornquist, HFE NEII 04/03/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 04/09/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1982 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00140 (L31)

30. REMARKS
Posted 4/23/2013 ML

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
04/03/2013 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5249 April 10, 2013

Mr. William Brewer, Administrator
Good Samaritan Society - Glenwood Lakeview
515 Franklin Street South
Glenwood, Minnesota 56334

Dear Mr. Brewer:

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 April 3, 2013, the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Mr. William Brewer, Administrator
Good Samaritan Society - Glenwood Lakeview
515 Franklin Street South
Glenwood, Minnesota 56334

April 9, 2013

RE: Project Number S5249022

Dear Mr. Brewer:

On February 27, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 7, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 3, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 21, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 7, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 19, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 7, 2013, effective April 3, 2013 and therefore remedies outlined in our letter to you dated February 27, 2013, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245249	A. Building B. Wing	4/3/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **04/03/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/03/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/03/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/03/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/03/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/cbl	04/09/2013	31593	04/03/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/7/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245249	A. Building 01 - MAIN BUILDING 01 B. Wing	3/21/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	03/15/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/cbl	04/09/2013	27200	03/21/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/6/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: LGOE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00969

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245249**
2.STATE VENDOR OR MEDICAID NO.
(L2) **050318500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW**
(L4) **515 FRANKLIN STREET SOUTH**
(L5) **GLENWOOD, MN** (L6) **56334**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/07/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/30

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the Standard survey, the facility was not in substantial compliance with Federal certification regulations. Please refer to the CMS 2567B along with the facility's plan of correction. Post Certification Revisit to follows.

17. SURVEYOR SIGNATURE — Date :
Angela Hofman, HFE NEII — 03/22/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist 04/02/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 04/03/2013 CO LGOE

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5976

February 27, 2013

Mr. William Brewer, Administrator
Good Samaritan Society - Glenwood Lakeview
515 Franklin Street South
Glenwood, Minnesota 56334

RE: Project Number S5249022

Dear Mr. Brewer:

On February 7, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Telephone: (218) 332-5140

Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 19, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 19, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

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

Failure to submit an acceptable PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 7, 2013 (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 August 7, 2013 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 332-5140 Fax: (218) 332-5196

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	GENERAL DISCLAIMER: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and state law. For purposes of any allegation that the facility is not in substantial compliance with Federal requirements for participation, this response and plan of correction constitutes the facility's allegations of compliance in accordance with Section 7305 of the State Operations Manual.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary condition for 1 of 10 resident's (R17) personal room and for 1 of 16 resident bathrooms (R15, R22 shared). Findings include: Soiled flooring in resident room During observation on 2/4/13, at 4:25 p.m., the floor under R17's bed had a thick layer of a dark substance, sand like texture, which covered the entire floor area under the resident's queen size bed.	F 253	F253 1) The flooring in room 2 has been replaced with new sheet vinyl so that it no longer has the black residue under the resident's bed. The flooring in the shared bathroom between rooms 19 and 20 has been replaced. The stool has been replaced with no shims being used. 2) All residents who live in the facility have the possibility of being affected by this deficient practice and they can, and should, expect to be able to reside in a building with a sanitary, orderly and comfortable interior. OK 3/22/13 Lsa	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William A Brewer, LNHA | TITLE: Administrator | (X6) DATE: 03/12/13

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.

RECEIVED
MAR 15 2013
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	02/07/2013

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GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

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F 253	Continued From page 1 An environmental tour of the facility was conducted with the maintenance director (MD)-A on 2/5/13, at 3:30 p.m. The large area under R17's bed remained dirty. MD-A indicated he was unable to identify the substance and stated he would expect all surfaces in resident rooms to be cleaned on a routine basis. Soiled shared bathroom During observation on 2/4/13, at 7:19 p.m. the shared bathroom of R15 and R22 had a strong urine like odor, the floor in front of the toilet was sticky, and two wooden shims (wedges) under the base of the toilet between the back of toilet and flooring were observed. Both wooden wedges appeared wet and stained with a black material. During the environmental tour on 2/5/13, at 3:30 p.m., the above findings of the shared bathroom for R15 and R22 were again observed. MD-A stated one of the residents had a history of urinating on the floor, agreed the wedges would be uncleanable and stated, "Soiled shims would not help with the smell." The facility housekeeping procedures titled Restroom Cleaning read, "Purpose * To maintain clean, hygienic and attractive surroundings." The policy gave direction for cleaning bathroom floors with specific direction for "excretion spills."	F 253	3) All Housekeeping staff will be re-trained to observe for unsanitary conditions when they make their rounds each day. If items are noted they will insert them into the "Maintenance Book" at the nurses station for repair or replacement. The Maintenance Department will then take appropriate steps to ensure that changes are made. 4) Random Audits of the "Maintenance Book" will be completed by the Housekeeping Supervisor or designee twice monthly x 3 months to ensure that needed repairs/replacements are being reported and completed by Maintenance staff. Audits will be reported to QA for further recommendations. 5) Completion Date: March 17, 2013.	3-14-13
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279	F 279 1) Resident 21 passed away on 1/16/13. 2) An observation skin assessment and Braden scale was completed on all current residents. Care plans updated if warranted to include current skin issues and interventions.	

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F 279	Continued From page 2 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive plan of care for 1 of 1 residents (R21) in the sample who had develped pressure ulcers in the facility. Findings include: A review of R21's record was conducted on 2/7/13. R21 had been admitted to the facility on 10/9/12, and the initial skin examination identified intact skin. Review of the nurses notes from 10/9/12 to 1/16/13 revealed on 10/9/12, R21 developed the following stage 2 pressure ulcers:on 10/11/12, a 0.2 x 0.3 centimeters (cm) open area on upper right buttock, on 10/29/12, an area on the coccyx measured 0.2 cm round on	F 279	3) All newly admitted residents and residents have a change in condition related to skin will have a Braden scale completed and a skin observation completed and care plans will include all current skin conditions. Nursing staff were re-educated on March 12th in making sure the care plan is kept current for all new skin issues and interventions and communication of these interventions is done with C.N.A.'s . Discussed the need to make sure all current repositioning schedules are included on the care plan to show on the kiosks. New interventions, including new positioning schedules will be reported to the C.N.A.'s during shift to shift communication. 4) Audits will be completed by DNS or designee to ensure that current skin issues and current skin interventions are on the care plan. These audits will be done weekly x 4 with results to QA for further recommendations. 5. Completion Date; March 19, 2013.	3-19-13

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F 279	Continued From page 3 right coccyx, on 11/13/12 the upper right buttock area increased in size from 0.2 x 0.3 cm to 1.5 X 0.4 cm. These pressure ulcers were not healed at the time R21 passed away at the facility on 1/16/13. R21's diagnosis included diabetes and terminal pancreatic cancer. R21's admission Minimum Data Set (MDS) dated10/15/12, identified R21 required extensive assistance for activities of daily living including extensive assistance by two staff for bed mobility. R21's care plan dated 10/24/12, identified R21 was independent with bed mobility and lacked direction for interventions for repositioning. Review of R21's "Incident Details" (a document used for identified resident problems) of the 1st noted pressure ulcer dated 10/12/12, identified "reposition side/side every 1/1/2 -2 hrs." This intervention was not implemented in the care plan. During interview on 2/7/13, at 11:23 a.m. the director of nursing (DON) confirmed R21 had developed pressure ulcers while in the facility. She confirmed R21's MDS and confirmed the care plan lacked direction for pressure ulcer interventions.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in accordance with the resident plan of care for 2 of 3 residents (R5, R25) with a history of falls in the sample. Findings include: R5's plan of care directed staff to use a gait belt with all transfers; however, a gait belt was not used on 1/15/15, which resulted in a fall. The plan of care, dated 12/12/12, identified R5 had general weakness, history of falls, and inablilty to safely transfer, and listed various interventions which included staff to utilize a gait belt and assist of one for all transfer. During an interview with R5 at 9:00 a.m., on 2/6/13, R5 stated she had fallen while being transferred from her wheelchair in the recent past. She stated the nursing assistant was rushing and had not used a gait belt to assist her to transfer from the wheelchair. R5 stated the nursing assistant "dropped me to the floor," during the transfer. R5 stated, "The therapist said staff must always use a gait belt when helping me." An interview with the director of nursing (DON) was conducted at 8:40 a.m., on 2/7/12. The DON confirmed R5's current plan of care and indicated the nursing staff had not utilized a gait belt for R5 during the recent fall. The DON confirmed she would expect a gait belt to be uitlized for all R5's	F 282	F 282 1) A gait belt is used for all of resident #5's transfers. Resident #25 has a personal safety alarm in the wheelchair and clipped to resident's clothing while in the wheelchair. Call light will also be in reach when in resident room. C.N.A.'s delivering care to these residents were talked to regarding the need to follow the care plan for these residents. 2) All C.N.A.'s working with current residents requiring assistance with transfer are using a gait belt for all transfers. Residents currently requiring a wheelchair alarm on while in wheelchair have the alarm placed and attached to the resident. 3) All resident requiring assistance with transfers and those needing a wheelchair alarm will have transfer belts used and alarms in wheelchair and connected to resident. Education was provided to the nursing staff on March 12th reviewing the need to follow the care plan for all care. Reviewed with C.N.A.'s that they need to use a gait belt for any resident requiring assistance with transfer and to make sure any type of alarm being used is in working order, in place and attached if indicated, based on the type of alarm. 4) Observation audits will be done by DNS or designee to ensure gait belts are being used during transfers. These audits will be done 3 x weeks for 4 weeks with results to QA for further recommendations. Observation audits will also be done on wheelchair alarms to make	

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F 282	Continued From page 5 transfers. R25's care plan directed staff to utilize a personal safety alarm in the wheelchair. However, a personal safety alarm was not in place on 2/6/13 and 2/7/13. Review of R25's care plan, revised 1/14/13, directed staff to utilize a TABS(an alarm box clipped to resident's clothing) while resident is in wheelchair. During observation on 2/6/13 at 8:47 a.m., nursing assistant (NA)-A and NA-D brought R25 to the commode in her room, then helped her back into her wheel chair. They did not attach the TABS alarm to the resident. During continuous observation from 9:03 a.m. through 9:32 a.m., R25 was sitting in her room alone and her call light was not within reach. A TABS alarm box was observed on the back of R25's wheelchair, however, the cord from the box was not attached to the resident during the entire observation. R25 was brought to the chapel by facility staff at 9:32 a.m., and remained in chapel for devotions from 9:40 a.m. to 10:49 a.m., TABS alarm box remained on the wheelchair, not attached to the resident for the entire observation period. During observation on 2/7/13 at 11:30 a.m., R25 was sitting alone in her room in her wheelchair and TABS alarm was not attached to the resident. In addition, R25 did not have the call light within	F 282	sure they are in place and clipped to resident. These audits will be done 3 x week for 4 weeks with results to QA for further recommendations. 5. Date of Completion; March 19, 2013.	3-19-13

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F 282	Continued From page 6 reach of her wheelchair. During interview on 2/7/13 at 11:30 a.m., R25 stated, "I will use the call light sometimes if I want to get up, but if I'm feeling feisty, I will get up on my own." During interview on 2/7/13 at 11:40 a.m., licensed practical nurse (LPN)-A confirmed R25 did not have the TABS alarm applied and stated she would apply the alarm immediately. LPN-A confirmed R25 required the TABS alarm to be in use at all times when she is in the wheelchair. During interview on 2/7/13 at 12:09 p.m., the director of nursing (DON) confirmed R25's current care plan and stated she would expect the TABS alarm to be applied to the resident at all times.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 review, the facility failed to provide a safe environment free of accident hazards for 2 of 3 residents (R5, R25) who required interventions to prevent further falls in the sample.	F 323	F 323 A gait belt is used for all of resident 5 and resident 25 transfers. R 25 has a personal safety alarm in the wheelchair and clipped to resident's clothe while in the wheelchair. Call light will also be in reach when in resident room. Current care plans reviewed and new fall interventions put in place if indicated. 2) All residents who have fallen since January 1st were reviewed to ensure that fall interventions have been implemented and are on the care plan. All C.N.A.'s or licensed nurses working with current residents requiring assistance with transfers are using a gait belt for all transfers to prevent or minimize falls and those resident requiring a TAB alarm,	

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F 323	Continued From page 7 Findings include: R5 was identified as a fall risk and had a fall on 1/15/13 during a transfer with staff assist from her recliner to her wheelchair. She was not wearing a gait belt. R5 had diagnoses which included muscle weakness, history of falls, and recent cerebrovascular accident. The admission Minimum Data Set (MDS), dated 12/4/12 , identified R5 was cognitively intact, and required extensive assist with bed mobility, transfers, toileting, and bathing. The plan of care dated 12/12/12, identified R5 had self care deficit related to general weakness, mobility deficit, history of falls, limited range of motion (ROM) on left side, weakness, and inability to safely transfer in and out of bed or to wheelchair/recliner. The care plan listed various interventions which included one staff assistance with transfers and use of a gait belt for transfers. In review of R5's medical record, an Incident Report dated 1/15/13, identified a fall had taken place in R5's room during a transfer. The report explained R5 had lost her balance during a transfer and then sat on the floor. The Incident Report, section D, entitled "Equipment in Use," indicated a gait belt was not in use at the time of the fall. An observation was made at 8:32 a.m., on 2/6/13, which revealed R5 required assistance from one staff to get up from her recliner chair and pivot toward her wheelchair. Nursing assistant (NA)-A	F 323	have the alarm on and clipped to resident clothing. All current residents when in room will have call light within reach. 3) All resident who are identified as fall risks and those at the time of a new fall will have new interventions identified within their care plan. Nursing staff were re-educated on March 12th to emphasize the importance of implementing new interventions at the time of the fall and updating the care plan with these new interventions at the time of the fall. New interventions will be added to the care plan and will be reported to the C.N.A.'s and other licensed nurses during shift to shift communication. Reviewed with C.N.A.'s and licensed nurses that they need to use a gait belt for any resident requiring assistance with transfers. 4) Observation audits will be done by the DNS or designee to ensure gait belts are being used during transfers to prevent or minimize falls and that all specific individualized fall interventions are on the care plan and are being followed. These audits will be done 3 x week for 4 weeks and will be reviewed weekly with the falls committee with results to QA for further recommendations. 5) Completion Date; March 19, 2013.	3-19-13

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F 323	Continued From page 8 placed a gait belt around R5's waist, held on to the belt while providing cues to R5 throughout the transfer. During an interview at 9:00 a.m., on 2/6/13, R5 stated she had fallen in the recent past because a gait belt had not been utilized during a transfer. She stated the nursing assistant was in a rush and "dropped me to the floor," while being transferred from her wheelchair. R5 stated the nursing assistant had not used a gait belt during the transfer. R5 stated, "the therapist said staff must always use a gait belt when helping me." During interview at 9:15 a.m., on 2/6/13, nursing assistant (NA)-A explained a gait belt must always be used when assisting R5 and all other residents An interview with the director of nursing (DON) was conducted at 8:40 a.m., on 2/7/12. The DON confirmed R5's current care plan, and indicated a gait belt had not been utilized resulting in the resident falling. The DON verified she would expect a gait belt to be used at all times for R5 to prevent or minimize further falls. An interview was conducted with the facility's Certified Occupational Therapy Assistant (COTA) at 9:32 a.m., on 2/7/13. She stated the standard of care for assisting residents with transfers was to always use a gait belt because it provides stability and guidance for the resident and for the staff. She confirmed residents should be wearing a gait belt with every transfer. A facility policy entitled, Gait (Transfer) Belt, dated 1/09, identified the purpose of using a gait	F 323		

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F 323	Continued From page 9 belt was to safely transfer or ambulate a resident, to aid residents in maintaining balance, and to avoid injury to both resident and the staff. Further, the policy identified, "Gait belt used unless medically contraindicated." R25 had 3 recent falls, with the most recent fall on 1/13/13. The facility put in place an intervention to use a TABS alarm (an alarm box clipped to resident's clothing) at all times for the resident. R25 was observed multiple times without the TABS alarm utilized for the resident. R25 had diagnoses that included vertigo, hypotension, mild dementia, schizophrenia and depression. The quarterly Minimum Data Set (MDS) dated 12/6/2012, identified R25 had moderate cognitive impairment, and required extensive assistance of two staff for activities of daily living (ADL's). Review of R25 care plan, revised 1/14/13, directed the use of a TABS alarm to be on while resident is in wheelchair. Review of incident reports revealed the following: On 10/3/12, R25 was found on the floor in her room, slipped out of wheelchair. No interventions put into place. On 11/10/12, R25 was found on floor in her room. She lost her balance and hit her head, bruise on head 3 cm x 16 cm, laceration on head	F 323		

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F 323	Continued From page 10 7 cm x 1cm. Interventions: Encouraged resident not to transfer self. On 1/13/13, R25 was found lying on floor in room. Resident lost balance. Resident hit head and right elbow. 2.2 cm (centimeter) x2.3 cm laceration, no indication on location of laceration. Intervention: alarm in wheelchair. Review of the nursing notes revealed on 1/26/13, R25 attempted to get up x4 this evening from wheelchair, having hallucinations of pigs running around in room. During observation on 2/6/13 at 8:47 a.m., nursing assistant (NA)-A and NA-D brought R25 to the commode in her room, then helped her back into her wheelchair. They did not attach the TABS alarm to the resident. During continuous observation from 9:03 a.m. through 9:32 a.m., R25 was sitting in her room alone and her call light was not within reach. A TABS alarm box was observed on the back of R25 wheelchair, however the cord from the box was not attached to the resident during the entire observation. R25 was brought to the chapel by facility staff at 9:32 a.m., and remained in chapel for devotions from 9:40 a.m. to 10:49 a.m., TABS alarm box remained on the wheelchair, not attached to the resident for the entire observation period. During observation on 2/7/13 at 11:30 a.m., R25 was sitting alone in her room in her wheelchair and TABS alarm was not attached to the resident. In addition, R25 did not have the call light within reach of her wheelchair.	F 323		

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F 323	Continued From page 11 On 2/7/13 at 11:30 a.m., R25 stated, "I will use the call light sometimes if I want to get up, but if I'm feeling feisty, I will get up on my own." During interview on 2/7/13 at 11:40 a.m., licensed practical nurse (LPN)-A confirmed R25 did not have the TABS alarm applied and stated she would apply the alarm immediately. LPN-A confirmed R25 required the TABS alarm to be in use at all times when she is in the wheelchair. During interview on 2/7/13 at 11:41 a.m., NA-A stated R25 was to have the TABS alarm on all the times, and stated "She leans forward and can fall out of her wheelchair." During interview on 2/7/13 at 12:09 p.m., the director of nursing (DON) confirmed R25's current care plan and stated she would expect the TABS alarm to be applied to the resident at all times.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F 371 1) The nursing assistant on 2/4/13 was spoken to and reviewed the proper gloving technique to be used while serving food (Dietary Services manual – "Food Handling"). This was done on 2/4/13. 2) The facility will serve food to all residents in a safe and sanitary manner. 3) All residents admitted to this center will have food distributed in an approved manner using the correct food handling technique. Nursing and Dietary staff responsible for the preparation and serving of food to residents will be re-trained in	

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	245249	A. BUILDING _____ B. WING _____	02/07/2013

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F 371	Continued From page 12 Based on observation, interview and document review, the facility failed to serve food in a sanitary manner for 2 of 4 residents (R15, R8) who required assistance with eating. Findings include: During observations on 2/4/13, at 5:34 p.m., nursing assistant (NA)E was observed sitting at a table with R15, R8 and two other residents. NA-E assisted R15 and R8 to eat the evening meal. NA-E reached out with his bare hand, picked up a sandwich from R8's plate and brought the sandwich half to R8's mouth for a bite of the sandwich. After returning the sandwich half to R8's plate, NA-E immediately picked up R15's sandwich half and brought it to R15's mouth. NA-E continued this practice of picking up the sandwich halves for both R8 and R15 with his bare hands until R8 and R15 had consumed their sandwiches. During interview on 2/4/13, at 5:40 p.m. NA-E confirmed that this was usual practice to pick up resident's sandwiches with bare hands, stating, " I use one hand for each resident." During interview on 2/6/13, at 1:33 p.m. the dietary manager confirmed staff are not to touch foods with bare hands. She stated, "Deli-papers are to be used or a knife and fork." During interview on 2/7/13, at 9:16 a.m. the director of nursing (DON) confirmed staff should not touch food directly, and stated, "A fork or knife should be used to cut and serve it." The facility policy titled Food/Food Preparation,	F 371	the proper technique of food handling on March 12th. 4) Random audits by the Dietary Supervisor or designee will be completed to ensure staff are appropriately utilizing approved food handling techniques. These audits will be completed weekly x 4 weeks with results to QA for further recommendations. 5) Completion date: March 15, 2013.	3-15-13

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F 371	Continued From page 13 Food Handling read "Purpose * To limit contamination of food served to a highly susceptible population." "Policy * Food will be handled in a manner that minimizes the risk of contamination." "Procedure 1. Ready-to-eat foods will not be touched with bare hands. Proper utensils such as tissue, spatula, tongs, single-use gloves, etc., will be used for food handling."	F 371		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Good Samaritan Center - Glenwood Lakeview was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	GENERAL DISCLAIMER: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and state law. For purposes of any allegation that the facility is not in substantial compliance with Federal requirements for participation, this response and plan of correction constitutes the facility's allegations of compliance in accordance with Section 7305 of the State Operations Manual. POC ok 3-18-13 RECEIVED MAR 18 2013	

EXIT: 02.07.2013 DC: 03.19.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William L Brewer, LNHA	Administrator	3-13-13

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

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lakeview Good Samaritan Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1965, an addition was added to the north that was determined to be of Type II(111) construction. In 1985 an addition was added to the north that was determined to be of Type II(000) construction which is protected by a fire sprinkler system. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a	K 000		

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K 000	Continued From page 2 fire alarm system with smoke detection in the areas open to the corridors and by the smoke barrier doors that is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the	K 052	K 052 *Step 1.* The facility will monthly test the Digital Alarm Communications Transmitter (DACT) to meet NFPA standards. The Maintenance Supervisor will document each test to verify the test has occurred. *Step 2.* Completion Date: March 15, 2013. *Step 3.* The Maintenance Supervisor will monthly complete the test of the Digital Alarm Communications Transmitter (DACT) to assure the safety of all residents, visitors and staff. Documentation will be completed on the TELS report system. The Administrator/designee will quarterly inspect the documentation to ensure that the required testing is occurring.	3-15-13

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K 052	Continued From page 3 facility. Findings include: On facility tour between 9:00 AM to 11:00 PM on 02/06/2013, during a documentation review of the available fire drill reports and fire alarm testing documentation for the last 12 months and interview with the Maintenance Supervisor (GB), it was revealed that the facility failed to document and/or conduct 4 of 12 monthly tests of the fire alarm DACT system. This deficient practice was verified by the Maintenance Supervisor (GB).	K 052		