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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MQKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00146

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245403**
2.STATE VENDOR OR MEDICAID NO.
(L2) **150518100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BATTLE LAKE**
(L4) **105 GLENHAVEN DRIVE**
(L5) **BATTLE LAKE, MN** (L6) **56515**

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 **09/29/2015** (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)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 10/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/07/2015 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/24/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245403

October 7, 2015

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, Minnesota 56515

Dear Mr. Wolf:

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

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

Effective September 25, 2015 the above facility is certified:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 7, 2015

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, Minnesota 56515

RE: Project Number S5403024

Dear Mr. Wolf:

On August 28, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 14, 2015. 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 September 29, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 2, 2015 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 August 14, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 14, 2015, effective September 25, 2015 and therefore remedies outlined in our letter to you dated August 28, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245403	A. Building B. Wing	9/29/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**09/25/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**09/25/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**09/25/2015**
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 State Agency	**Reviewed By** GA/mm	**Date:** 10/07/2015	**Signature of Surveyor:** 28034	**Date:** 09/29/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/14/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245403	A. Building B. Wing **01 - MAIN BUILDING 01**	10/2/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/24/2015**	ID Prefix	Correction Completed **09/18/2015**	ID Prefix	Correction Completed **09/30/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0046		LSC K0047		LSC K0056	
ID Prefix	Correction Completed **08/20/2015**	ID Prefix	Correction Completed **09/24/2015**	ID Prefix	Correction Completed **08/20/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0062		LSC K0067		LSC K0073	
ID Prefix	Correction Completed **09/17/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0144		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/mm	10/07/2015	27200	10/02/2015
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
8/17/2015	

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
245403	A. Building B. Wing **02 - 2007 CONNECTING LINK**	10/2/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/20/2015**	ID Prefix	Correction Completed **08/20/2015**	ID Prefix	Correction Completed **09/24/2015**
Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0067	
ID Prefix	Correction Completed **08/20/2015**	ID Prefix	Correction Completed **09/17/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0073		Reg. # **NFPA 101** LSC K0144		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/mm	10/07/2015	27200	10/02/2015
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
8/17/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MQKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00146

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245403**
2.STATE VENDOR OR MEDICAID NO.
(L2) **150518100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BATTLE LAKE**
(L4) **105 GLENHAVEN DRIVE**
(L5) **BATTLE LAKE, MN** (L6) **56515**

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 **08/14/2015** (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)
12/31

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (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
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Christina Martinson — 09/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/16/2015 (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
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 28, 2015

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, Minnesota 56515

RE: Project Number S5403024

Dear Mr. Wolf:

On August 14, 2015, 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:

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

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

Remedies - 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, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 23, 2015, 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 September 23, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 14, 2015 (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 February 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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 electronic 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. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: gary.schroeder@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF 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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		9/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/04/2015

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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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA) and failed to complete a thorough investigation for 2 of 2 residents (R15, R3) for injuries of unknown origin and potential neglect of care, reviewed for abuse prohibition. Findings include: R15's injury of unknown origin was not reported to the SA and thoroughly investigated. R15's quarterly MDS dated 7/21/15, identified R15 had diagnoses which included dementia, delusional disorder, depression, and anxiety. The MDS identified R15 had moderately impaired cognitive skills for daily decision making and both short-term and long-term memory problems. Further, the MDS identified R15 required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, personal hygiene	F 225	1. Incidents for R15 and R3 have been reported to OHFC per facility policy and procedure. A subsequent investigation report has been filed for each of the incidents reported. 2. All residents within the facility are identified as having the potential to be affected by this same deficient practice. All incident reports will be reviewed by the DON, SS, and administrator to ensure compliance with the facility abuse prevention plan. 3. The administrator, DON, social worker, or designee will review and revise, as necessary, internal processes of reporting/investigating abuse, neglect, and resident to resident altercations. The DON, social worker or designee provided education to nursing staff on 8/26/15 and	

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F 225	Continued From page 2 and bathing. Review of R15's care plan dated 3/31/15, revealed R15 had impaired cognition function relation to CVA, delirium and confusion. The care plan indicated R15 would forget cares just completed by staff, was difficult to re-direct, had poor judgement with decisions resulting in needing assistance with decisions and verbalizations. Review of R15's incident report dated, 4/12/15, revealed staff had heard an alarm and found R15 on the floor in the bathroom doorway. The report described R15 lying with his head next to the bathroom doorway, and R15 reported he was going to the bathroom. The report identified R15 had impaired memory, impaired vision, and drowsiness. Further, the report identified no witnesses were found of the incident and listed R15 had multiple skin tears and was bleeding from the right temple and left inner forearm and did not report pain. Review of R15's progress notes dated 4/12/15 revealed the following: -4:30 a.m., nursing assistant found R15 lying on the floor in front of the bathroom doorway. R15 had bleeding at the temple, and multiple skin tears. R15 had been assisted from the floor into bed by facility staff and a mechanical lift device. -6:10 a.m., when assisted to ambulate, R15 could not bear full weight on the right leg and right leg was slightly turned outward. R15 complained of dizziness, pain and had a small emesis. The note indicated R15 had been transferred to the hospital for evaluation on 4/12/15 at 7:45 a.m., at	F 225	9/1/15 on the facility policy and procedure related to the abuse prevention plan. Staff will continue to be educated on this practice upon hire. 4. To monitor performance related to the responsibilities of reporting to the SA, all incident reports will be audited by the DNS or designee x4 weeks, and then randomly x3. All audit findings will be reported to the monthly QA meeting for further recommendation. 5. Completion Date: September 25, 2015	

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F 225	Continued From page 3	F 225		

10:00 a.m. the facility was contacted to confirm R15's hip fracture and would require surgical repair of the hip fracture.

During interview on 08/13/15 at 11:24 a.m., trained medication aide (TMA)-A-reported R15 had very poor memory and had a difficult time concentrating or recalling past events.

During interview on 8/13/15 at 4:59 p.m., registered nurse (RN)-A stated R15 had dementia, poor memory recall and required redirection. RN-A stated R15 developed pain after the 4/12/15 fall, was sent to the hospital for evaluation and had been diagnosed with fractured hip which required surgical repair. RN-A confirmed R15's fall was not witnessed by any staff, confirmed the facility had assumed R15 fell. RN-A stated she has never viewed this as an injury of unknown origin, even though R15 has dementia with poor memory, and was diagnosed with significant injury.

During interview on 08/13/15 at 11:28 a.m., the DON confirmed R15 had an unwitnessed fall on 4/12/15 and was found on floor with walker in bathroom doorway. The DON reported R15's cognition fluctuated and confirmed R15 was not a reliable source for information. The DON stated the facility had not previously taken into consideration the reporting requirement regarding unexplainable injuries of unknown source with cognitively impaired residents. The DON confirmed R15's incident lacked a thorough investigation.

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F 225	Continued From page 4	F 225		

R3's injury of unknown origin and potential neglect of care was not reported to the SA and thoroughly investigated.

R3's significant change MDS dated 4/29/15 identified R3 had diagnoses which included arthritis, osteoporosis, and dementia. Further, the MDS identified R3 had severe cognitive impairment and required extensive assistance with all activities of daily living.

Review of R3's incident report, dated 4/26/15, revealed R3 was found lying on her back on the floor in her room. R3 had hollered out in pain and held her chest area when staff attempted to move her. The report identified R3 had an abrasion to the face and a bruise on the back of the right hand. The report identified there were no

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F 225	Continued From page 5	F 225		

witnesses found and R3 did not remember falling 15 minutes after episode due to confusion, impaired memory and gait imbalance.

Review of R3's progress notes from 4/26/15 to 4/28/15 revealed the following:

-On 4/26/15, at 2:57 p.m. R3 was found lying on her back on the floor of her room. Noted to have a abrasion on forehead with no drainage, with slight swelling in area. R3 stated she had been on her way to the bathroom, and indicated she did not remember falling. R3 hollered out in pain when attempted to move and indicated her mid chest area hurt. R3's left side of chest was noted to be more elevated then right side and an ice pack was applied to chest area & forehead.

Further, the progress note identified at 11:15a.m. R3 was observed to holler out in pain and hold chest area when staff attempted to provide cares. R3 had rapid respirations and low oxygen levels at that time, and administration of oxygen (O2) was attempted. Call placed again to Dr. for Morphine order for residents comfort, staff has been unable to assist resident due to pain, also requested prn O2 order if resident needed.

-On 4/28/15, at 2:02 p.m. DON identified R3 had a fall with injury on 4/26/15. Now has sensor alarm pad while in bed as resident requires assist with transfers and ambulation due to increased pain to chest. Staff continue to work closely with MD related to morphine use and suspected injury to sternum. Family agreed resident should stay within the confines of the nursing home for resident comfort and well-being.

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During interview on 8/13/14 at 4:25 p.m. the administrator confirmed the current facility policy and indicated the facility policy included decision trees which staff utilized to determine when to report to the SA. He indicated the usual facility practice was to immediately report to the SA injuries of unknown origin, resident to resident altercation, and falls which resulted in fractures. The administrator stated "we should be following the written policy." He indicated the facility may not be interpreting the tools appropriately.

On 08/14/15, at 9:05 a.m. during interview the DON reviewed incident on 4/26/15. She stated R3 took herself to the bathroom and fell. She stated, "We know she took herself to bathroom, because she didn't take any staff with her, and that's what she told us happened." She stated they suspected a significant injury happened at that time because of R3's chest pain and holding her chest. She stated the facility had not reported the incident because R3's care plan was followed, and stated that was what the staff looked at to determine if it was reportable or not. She stated the incident had not been reported to the SA because R3's care plan was followed. She stated R3 did not get medical treatment because it is difficult to get her to eat or shower, and because she was very paranoid related to her disease process. She stated for the facility to transport R3 to the hospital it would be more traumatizing, and they likely would not have done anything for her suspected injury, and that's why there was nothing done.

Review of facility policy titled, Abuse And Neglect, revised on 9/13, directed staff to report alleged or suspected violations involving any mistreatment, neglect, abuse including injuries of unknown

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F 225	Continued From page 7 origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency. The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Review of the decision tool provided by the facility titled MN Nursing Home Decision Tool to Determine Potential Reportability and Facility Follow Up Process for Resident to Resident Altercation dated 6/13, identified situations when an incident was reportable to the SA. In addition, the form identified the tool should be used in conjunction with applicable federal nursing home regulations and is not intended to replace professional judgement or legal advice. Review of the decision tool provided by the facility title Federal Long Term Care Reportablity for Injures of Unknown Source under F225 form , dated 5/13 identified situations when an incident was reportable to the SA. In addition, the form identified the tool was optional, if used, this tool is to be used in conjunction with applicable Federal Nursing Home regulations. Causes of injuries may also be reportable as mistreatment, abuse, or neglect.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		9/25/15

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F 226	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse and neglect policy and procedures related to immediatel notification to the state agency (SA) and conduct a thorough investigation for 2 of 2 residents (R15, R3) reviewed for abuse prohibition with significant injuries of unknown origin and potential neglect of care. Findings include: Review of facility policy titled, Abuse And Neglect, revised on 9/13, directed staff to report alleged or suspected violations involving any mistreatment, neglect, abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency. The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Review of the decision tool provided by the facility titled MN Nursing Home Decision Tool to Determine Potential Reportability and Facility Follow Up Process for Resident to Resident Altercation dated 6/13, identified situations when an incident was reportable to the SA. In addition, the form identified the tool should be used in conjunction with applicable federal nursing home regulations and is not intended to replace professional judgement or legal advice.	F 226	1. Incidents for R15 and R3 have been reported to OHFC per facility policy and procedure. A subsequent investigation report has been filed for each of the incidents reported. 2. All residents within the facility are identified as having the potential to be affected by this same deficient practice. All incident reports will be reviewed by the DON, SS, and administrator to ensure compliance with the facility abuse prevention plan. 3. The administrator, DON, social worker or designee will review and revise, as necessary, internal processes of reporting/investigating abuse, neglect, and resident to resident altercations. The DON, social worker or designee provided education to nursing staff on 8/26/15 and 9/1/15 on the facility policy and procedure related to the abuse prevention plan. Staff will continue to be educated on this practice upon hire. 4. To monitor performance related to the responsibilities of reporting to the SA, all incident reports will be audited by the DNS or designee x4 weeks, an then monthly x3. All audit findings will be reported to the monthly QA meeting for further recommendation. 5. Completion Date: September 25, 2015	

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F 226	Continued From page 9	F 226		

Review of the decision tool provided by the facility titled Federal Long Term Care Reportablity for Injures of Unknown Source under F225 form , dated 5/13 identified situations when an incident was reportable to the SA. In addition, the form identified the tool was optional, if used, this tool is to be used in conjunction with applicable Federal Nursing Home regulations. Causes of injuries may also be reportable as mistreatment, abuse, or neglect.

R15's injury of unknown origin was not reported to the SA and thoroughly investigated.

R15's quarterly MDS dated 7/21/15, identified R15 had diagnoses which included dementia, delusional disorder, depression, and anxiety. The MDS identified R15 had moderately impaired cognitive skills for daily decision making and both short-term and long-term memory problems. Further, the MDS identified R15 required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing.

Review of R15's care plan dated 3/31/15, revealed R15 had impaired cognition function relation to CVA, delirium and confusion. The care plan indicated R15 would forget cares just completed by staff, was difficult to re-direct, had poor judgement with decisions resulting in needing assistance with decisions and verbalizations.

Review of R15's incident report dated, 4/12/15, revealed staff had heard an alarm and found R15 on the floor in the bathroom doorway. The report

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described R15 lying with his head next to the bathroom doorway, and R15 reported he was going to the bathroom. The report identified R15 had impaired memory, impaired vision, and drowsiness. Further, the report identified no witnesses were found of the incident and listed R15 had multiple skin tears and was bleeding from the right temple and left inner forearm and did not report pain.

Review of R15's progress notes dated 4/12/15 revealed the following:

-4:30 a.m., nursing assistant found R15 lying on the floor in front of the bathroom doorway. R15 had bleeding at the temple, and multiple skin tears. R15 had been assisted from the floor into bed by facility staff and a mechanical lift device.

-6:10 a.m., when assisted to ambulate, R15 could not bear full weight on the right leg and right leg was slightly turned outward. R15 complained of dizziness, pain and had a small emesis. The note indicated R15 had been transferred to the hospital for evaluation on 4/12/15 at 7:45 a.m., at 10:00 a.m. the facility was contacted to confirm R15's hip fracture and would require surgical repair of the hip fracture.

During interview on 08/13/15 at 11:24 a.m., trained medication aide (TMA)-A-reported R15 had very poor memory and had a difficult time concentrating or recalling past events.

During interview on 8/13/15 at 4:59 p.m., registered nurse (RN)-A stated R15 had dementia, poor memory recall and required redirection. RN-A stated R15 developed pain after the 4/12/15 fall, was sent to the hospital for

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evaluation and had been diagnosed with fractured hip which required surgical repair. RN-A confirmed R15's fall was not witnessed by any staff, confirmed the facility had assumed R15 fell. RN-A stated she has never viewed this as an injury of unknown origin, even though R15 has dementia with poor memory, and was diagnosed with significant injury.

During interview on 08/13/15 at 11:28 a.m., the DON confirmed R15 had an unwitnessed fall on 4/12/15 and was found on floor with walker in bathroom doorway. The DON reported R15's cognition fluctuated and confirmed R15 was not a reliable source for information. The DON stated the facility had not previously taken into consideration the reporting requirement regarding unexplainable injuries of unknown source with cognitively impaired residents. The DON confirmed R15's incident lacked a thorough investigation.
R3's injury of unknown origin and potential neglect of care was not reported to the SA and thoroughly investigated.

R3's significant change MDS dated 4/29/15 identified R3 had diagnoses which included arthritis, osteoporosis, and dementia. Further, the MDS identified R3 had severe cognitive impairment and required extensive assistance with all activities of daily living.

Review of R3's incident report, dated 4/26/15, revealed R3 was found lying on her back on the floor in her room. R3 had hollered out in pain and held her chest area when staff attempted to move her. The report identified R3 had an abrasion to

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(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 226	Continued From page 12	F 226		

the face and a bruise on the back of the right hand. The report identified there were no witnesses found and R3 did not remember falling 15 minutes after episode due to confusion, impaired memory and gait imbalance.

Review of R3's progress notes from 4/26/15 to 4/28/15 revealed the following:

-On 4/26/15, at 2:57 p.m. R3 was found lying on her back on the floor of her room. Noted to have a abrasion on forehead with no drainage, with slight swelling in area. R3 stated she had been on her way to the bathroom, and indicated she did not remember falling. R3 hollered out in pain when attempted to move and indicated her mid chest area hurt. R3's left side of chest was noted to be more elevated then right side and an ice pack was applied to chest area & forehead.

Further, the progress note identified at 11:15a.m. R3 was observed to holler out in pain and hold chest area when staff attempted to provide cares. R3 had rapid respirations and low oxygen levels at that time, and administration of oxygen (O2) was attempted. Call placed again to Dr. for Morphine order for residents comfort, staff has been unable to assist resident due to pain, also requested prn O2 order if resident needed.

-On 4/28/15, at 2:02 p.m. DON identified R3 had a fall with injury on 4/26/15. Now has sensor alarm pad while in bed as resident requires assist with transfers and ambulation due to increased pain to chest. Staff continue to work closely with MD related to morphine use and suspected injury to sternum. Family agreed resident should stay within the confines of the nursing home for resident comfort and well-being.

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	245403	A. BUILDING _____ B. WING _____	08/14/2015

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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F 226	Continued From page 13 During interview on 8/13/14 at 4:25 p.m. the administrator confirmed the current facility policy and indicated the facility policy included decision trees which staff utilized to determine when to report to the SA. He indicated the usual facility practice was to immediately report to the SA injuries of unknown origin, resident to resident altercation, and falls which resulted in fractures. The administrator stated "we should be following the written policy." He indicated the facility may not be interpreting the tools appropriately. On 08/14/15, at 9:05 a.m. during interview the DON reviewed incident on 4/26/15. She stated R3 took herself to the bathroom and fell. She stated, "We know she took herself to bathroom, because she didn't take any staff with her, and that's what she told us happened." She stated they suspected a significant injury happened at that time because of R3's chest pain and holding her chest. She stated the facility had not reported the incident because R3's care plan was followed, and stated that was what the staff looked at to determine if it was reportable or not. She stated the incident had not been reported to the SA because R3's care plan was followed. She stated R3 did not get medical treatment because it is difficult to get her to eat or shower, and because she was very paranoid related to her disease process. She stated for the facility to transport R3 to the hospital it would be more traumatizing, and they likely would not have done anything for her suspected injury, and that's why there was nothing done.	F 226		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		9/25/15

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The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing techniques were followed during personal cares for 1 of 3 residents (R15) observed. In addition, the facility failed to ensure a mechanical lift was properly sanitized after use for 1 of 1 resident (R15). Findings include: R15's quarterly Minimum Data Set (MDS) dated 7/21/15, identified R15 had diagnoses which included diabetes, dementia and anxiety. The MDS identified R15 moderately impaired skills for daily decision making and had both short term and long term memory problems. Further, the MDS identified required extensive assistance of one staff for toileting activities. During continuous observation on 8/12/15,from 12:40 p.m. to 12:54 p.m., nursing assistant (NA)-A was observed while R15 was assisted to transfer from the wheelchair to the toilet. -at 12:40 p.m., NA-A applied disposable gloves on both hands and utilized a mechanical standing lift to transfer R15 from the wheelchair to the toilet. -at 12:42 p.m. NA-A loosened R15's pants, removed R15's incontinent product and lowered R15 onto the toilet and proceeded to remove the gloves from both hands. While seated on the toilet, R15 started coughing, and NA-A retrieved a tissue and handed to R15 to wipe his nose and mouth. R15 wiped his mouth and nose multiple	F 441	1. Proper infection control practices are being performed with all perineal care and mechanical lift sanitation. 2. All residents in this facility are at risk of being affected by this deficient practice. If infection control practices are not followed, education is provided immediately by the licensed staff. 3. Staff education was provided related to proper hand washing and lift-cleaning procedure on 8/26/15 and 9/1/15. Nursing staff continue to be encouraged to carry hand sanitizer on their person; wipes for lift sanitation are kept in bags on each lift. Extra wipes are kept in nursing storage closet. 4. DNS, infection control coordinator or designee will perform random observational audits weekly x4 and monthly x3 on infection control practices related to perineal care and mechanical lift sanitation. All audit findings will be reported to the monthly QA meeting for further recommendation. Completion Date: September 25, 2015	

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times with the tissue, then held the soiled tissue in his left hand while holding onto the mechanical lift handle.

-at 12:44 p.m. NA-A applied fresh gloves, utilized the mechanical lift to assist R15 to a standing position and proceeded to cleanse R15's perineal area with a wet wipe, removed one glove applied barrier cream and removed the other glove. R15 stated he needed to use the toilet again, NA-A immediately reached out and held the controls for the lift in one hand, and placed the other hand on the mechanical lift arm and lowered R15 back onto the toilet.

-at 12:46 p.m. NA-A applied fresh gloves, and proceeded to cleanse R15's perineal area with wet wipes, brown bowel observed on cleansing wipe. NA-A removed her gloves from both hands, immediately reach out to adjust R15's incontinent brief and pants and immediately transferred R15 into a recliner in the room.

-at 12:51 p.m. NA-A reached out, placed both hands on the mechanical lift and pushed the mechanical lift out of the doorway and hallway, to a alcove in the facility hallway.

NA-A had not washed her hands or performed hand hygiene during the entire observation.

During interview on 8/12/15, at 12:51 p.m. NA-A confirmed cares were complete for R15, and confirmed she had not sanitized or washed her hands after providing cares to R15. NA-A stated, "you caught me off guard." NA-A confirmed normal practice would be to wash or use hand sanitizer after removing gloves. NA-A reported housekeeping staff cleaned the mechanical lifts

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daily, and indicated nursing staff should wipe off the mechanical lifts with bleach wipes after each time a resident uses them. NA-A confirmed R15 had used the lift handle while holding it with a soiled tissue, then stated it should have been sanitized with a bleach wipe. NA-A reported it is not nursing staff's usual protocol to clean the lifts between each resident use, and did confirms facility mechanical lifts were equipped with sanitizing wipes in bags attached to the mechanical lifts.

During interview on 8/13/15, at 4:30 p.m. staff development coordinator confirmed a soiled tissue would warrant a mechanical lift disinfecting between resident use, and stated nursing staff were expected to disinfect the mechanical lifts in between resident uses. Further, the staff development coordinator confirmed all staff were expected to wash hands when visibly soiled after any kind of resident care, and were expected to perform hand hygiene/ sanitize when going in and out of resident rooms.

During interview on 8/14/15, at 1:09 p.m. the director of housekeeping stated the housekeeping staff cleaned all of the mechanical lifts daily, however, nursing staff were expected to also clean the lifts as needed after resident use. The director of housekeeping stated the lifts were equipped with disinfectant wipes in the tubs attached to the mechanical lifts.

During interview on 8/14/15, at 1:18 p.m. the director of nursing(DON) stated all staff were expected to wash and/or sanitize hands after removing gloves and before touching another surface. The DON reported the facility directed staff to keep hand sanitizer in their pockets for

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F 441	Continued From page 18 that purpose. The DON confirmed nursing staff were to wipe down all mechanical lifts with bleach wipes between resident uses if the lift becomes contaminated, and verified all nursing staff were educated regarding the requirement. The facility's Hand Hygiene and Handwashing Policy dated 6/14, directed staff to perform hand hygiene after removing gloves.	F 441		

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety State Fire Marshal Division. At the time of this survey Good Samaritan Society Battle Lake, 01 Main Building 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 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/10/2015

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 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was surveyed as two buildings. The Good Samaritan Society Battle Lake is a 1-story building, without a basement. The original building was built in 1973 and was determined to be Type II(000) construction. In 1994 additions to the south of the west wing and to the north of the north wing (Occupational and Physical Therapy - OT/PT) were constructed. The 1994 additions were determined to be Type V(111) construction. In 2004 a small vestibule was added to the west wing which included a walk in freezer, which is Type II (000) construction. In 2007 a connecting link, to the new assisted living apartments, was added to the south wing and was determined to be Type V (111). In 2010 an entrance addition was constructed to the north of the dining room which is 1-story, no basement and Type II (000) construction. In 2011 a 16 bed addition was	K 000		

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K 000	Continued From page 2 added to the east of the north wing and was determined to be Type II (111) and a 8 bed addition was added to the east of the south east wing and was determined to be Type II (111) construction. The building is divided into 3 smoke compartments by 30 minute rated fire barriers. The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition), that is monitored for automatic fire department notification. Additional automatic fire detection is provided in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 55 beds with a census of 53 residents at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in	K 046	Emergency battery powered lighting fixtures were disconnected and removed by Otter Electric Company. The entire	8/24/15

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K 046	Continued From page 3 accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, observations reveled the following deficient conditions affecting the battery backup emergency light: 1. During the review of available emergency battery backup emergency lighting maintenance documentation and interview with the Maintenance Supervisor (CS) revealed the that the facility failed to conduct the required Monthly 30 second and annual 90 minute testing of the battery backup emergency lights. 2. There is a battery backup emergency light located by the employee break room that was found to be inoperative at the time of the inspection. This deficient practices was confirmed by the Maintenance Supervisor (CS).	K 046	building is served by a 450 KW full-load emergency generator. Battery operated emergency lighting is not necessary and is disconnected perpetually.	
K 047 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 047		9/18/15

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K 047	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide 2 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The deficient practice could affect residents, staff and visitors, if the lack of properly illuminated exit sign prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, observations reveled the following deficient conditions affecting the facility's exit signs: 1. The facility had an illuminated style exit sign by the employee break room that was not illuminated. 2. The Heritage Day room has a door that leads to the outside of the building that is not a required exit that is not labeled as "NO EXIT" This deficient practices was confirmed by the Maintenance Supervisor (CS).	K 047	Burned out light bulbs in the exit lighting at the staff break room have been replaced by the maintenance department on 8/24/15. A process for checking all exit lighting has been put into the facility Preventive Maintenance system, and will be monitored by the facility Quality Assurance Process with routine audits monthly for 6 months and with quarterly audits for an additional year. A sign labeled as, "NO EXIT" is ordered and will be installed on the Heritage Day Room door that leads to the outside of the building.	
K 056 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the	K 056		9/30/15

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K 056	Continued From page 5 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015,, observations have revealed that there are 3 corroded sprinkler heads located in the kitchen. This deficient practices was confirmed by the Maintenance Supervisor (CS).	K 056	Replacement sprinkler heads will be installed by Nova Fire Protection, Inc. by 9/30/15. Facility sprinkler heads will be monitored by Nova Fire Protection, Inc. as part of their annual fire inspection survey. Facility Maintenance Director will schedule this test on an annual basis.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		8/20/15

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

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K 062	Continued From page 6 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, a review of documentation and interview with the Maintenance Supervisor (CS) revealed that at the time of the inspection the facility failed to provide any documentation for a current annual fire sprinkler test having been completed. This deficient practices was confirmed by the Maintenance Supervisor (CS).	K 062	A facility fire sprinkler test was performed on 8-20-15 by Nova Fire Protection Systems, Inc. An annual inspection will be scheduled by the facility Maintenance Director. On-going compliance with this standard will be monitored by the facility Maintenance Director as part of the physical plant preventive maintenance program.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067		9/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 7 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Supervisor (CS), that the facility had failed to provide documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years. This deficient condition was verified by the Maintenance Supervisor (CS).	K 067	A service contract has been established with Protection Service Systems to conduct a facility "smoke damper" test and provide documentation of the inspection/test. Compliance with this standard will be maintained by the facility Maintenance Director through the facility preventive maintenance program to be done once every 4 years.	
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4	K 073		8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 073	Continued From page 8 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 19.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, observations revealed that the facility could not verify if the decoration that are hanging on resident rooms 110, 112A, 214, and 317 doors are fire retardant of if they have been treated with any type of approved fire retardant treatment. This deficient practices was confirmed by the Maintenance Supervisor (CS).	K 073	The facility has removed all combustible non-complying decorations from public corridors and established a policy to restrict the use of combustible decorations in theses areas in the future. Enforcement will be monitored by the facility Quality Assurance Committee with routine audits performed monthly for the first 6 months and quarterly for an additional year. The Quality Assurance Director will be responsible to maintain compliance.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		9/17/15

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	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2015**

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

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K 144	Continued From page 9 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all patients, staff, and visitors. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, documentation review of the emergency generator testing logs and staff interview with the Maintenance Supervisor (CS) it was reveled that the facility could not provide complete weekly and monthly generator testing reports for their generator maintenance program. The facility had documented that they ran their emergency generator for the minimum required time; but the facility could not provide any written documentation at the time of the inspection that all the weekly and monthly generator maintenance checks were completed during the these maintenance intervals. This deficient condition was verified by the Maintenance Supervisor (CS).	K 144	Facility will acquire the acceptable documentation form from the State Fire Marshall Division and maintain regular reporting of all mandated operational functions of the emergency generator. The facility Director of Maintenance will be responsible to carry out this activity.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **02 - 2007 CONNECTING LINK** B. WING _____	**08/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515**

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Battle Lake 02 (16 and 8 bed additions) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

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

Electronically Signed | 09/10/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **02 - 2007 CONNECTING LINK** B. WING _____	**08/17/2015**

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515**

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or Angela.kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was surveyed as two buildings. The Good Samaritan Society Battle Lake is a 1-story building, without a basement. The original building was built in 1973 and was determined to be Type II(000) construction. In 1994 additions to the south of the west wing and to the north of the north wing (Occupational and Physical Therapy - OT/PT) were constructed. The 1994 additions were determined to be Type V(111) construction. In 2004 a small vestibule was added to the west wing which included a walk in freezer, which is Type II (000) construction. In 2007 a connecting link, to the new assisted living apartments, was added to the south wing and was determined to be Type V (111). In 2010 an entrance addition was constructed to the north of the dining room which is 1-story, no basement and Type II (000) construction. In 2011 a 16 bed addition was	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **02 - 2007 CONNECTING LINK** B. WING _____	**08/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515**

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K 000	Continued From page 2 added to the east of the north wing and was determined to be Type II (111) and a 8 bed addition was added to the east of the south east wing and was determined to be Type II (111) construction. The building is divided into 3 smoke compartments by 30 minute rated fire barriers. The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition), that is monitored for automatic fire department notification. Additional automatic fire detection is provided in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 55 beds with a census of 53 residents at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water	K 056		8/20/15

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K 056	Continued From page 3 supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015,, observations have revealed that there are two standard response type of sprinkler heads mixed in with quick response type sprinkler head that are located in the 16 plex mezzanine mechanical room. This deficient practices was confirmed by the Maintenance Supervisor (CS).	K 056	Complying sprinkler heads were installed in the 16-plex mezzanine mechanical room on 8/20/2015 by Nova Fire Protection Systems, Inc. The facility Director of Maintenance will monitor compliance with the noted standard on an annual basis.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		8/20/15

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K 062	Continued From page 4 condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, a review of documentation and interview with the Maintenance Supervisor (CS) revealed that at the time of the inspection the facility failed to provide any documentation for a current annual fire sprinkler test having been completed. This deficient practices was confirmed by the Maintenance Supervisor (CS).	K 062	Note detailed POC response for this tag under section titled "01- Main Building"	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067		9/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 067	Continued From page 5 specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Supervisor (CS), that the facility had failed to provide documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years. This deficient condition was verified by the Maintenance Supervisor (CS).	K 067	Note detailed POC response for this tag under section titled "01- Main Building"	
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 18.7.5.2, 18.7.5.3, 18.7.5.4	K 073		8/20/15

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K 073	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 18.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, observations revealed that the facility could not verify if the decoration that are hanging on resident rooms 110, 112A, 214, and 317 doors are fire retardant of if they have been treated with any type of approved fire retardant treatment. This deficient practices was confirmed by the Maintenance Supervisor (CS).	K 073	Note detailed POC response for this tag under section titled "01- Main Building"	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by:	K 144		9/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 7 Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all patients, staff, and visitors. Findings include: On facility tour between 9:00 AM to 1:30 PM on 08/17/2015, documentation review of the emergency generator testing logs and staff interview with the Maintenance Supervisor (CS) it was reveled that the facility could not provide complete weekly and monthly generator testing reports for their generator maintenance program. The facility had documented that they ran their emergency generator for the minimum required time; but the facility could not provide any written documentation at the time of the inspection that all the weekly and monthly generator maintenance checks were completed during the these maintenance intervals. This deficient condition was verified by the Maintenance Supervisor (CS).	K 144	Note detailed POC response for this tag under section titled "01- Main Building"	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 28, 2015

Mr. James Wolf, Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, Minnesota 56515

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5403024

Dear Mr. Wolf:

The above facility was surveyed on August 10, 2015 through August 14, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us**.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00146	A. BUILDING: _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On August 10th,11th, 12th, 13th and August 14th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing techniques were followed during personal cares for 1 of 3 residents (R15) observed. In addition, the facility failed to ensure a mechanical lift was properly sanitized after use for 1 of 1 resident (R15). Findings include: R15's quarterly Minimum Data Set (MDS) dated 7/21/15, identified R15 had diagnoses which included diabetes, dementia and anxiety. The MDS identified R15 moderately impaired skills for daily decision making and had both short term and long term memory problems. Further, the MDS identified required extensive assistance of one staff for toileting activities.	21385	Corrected	9/25/15

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21385	Continued From page 3 During continuous observation on 8/12/15,from 12:40 p.m. to 12:54 p.m., nursing assistant (NA)-A was observed while R15 was assisted to transfer from the wheelchair to the toilet. -at 12:40 p.m., NA-A applied disposable gloves on both hands and utilized a mechanical standing lift to transfer R15 from the wheelchair to the toilet. -at 12:42 p.m. NA-A loosened R15's pants, removed R15's incontinent product and lowered R15 onto the toilet and proceeded to remove the gloves from both hands. While seated on the toilet, R15 started coughing, and NA-A retrieved a tissue and handed to R15 to wipe his nose and mouth. R15 wiped his mouth and nose multiple times with the tissue, then held the soiled tissue in his left hand while holding onto the mechanical lift handle. -at 12:44 p.m. NA-A applied fresh gloves, utilized the mechanical lift to assist R15 to a standing position and proceeded to cleanse R15's perineal area with a wet wipe, removed one glove applied barrier cream and removed the other glove. R15 stated he needed to use the toilet again, NA-A immediately reached out and held the controls for the lift in one hand, and placed the other hand on the mechanical lift arm and lowered R15 back onto the toilet. -at 12:46 p.m. NA-A applied fresh gloves, and proceeded to cleanse R15's perineal area with wet wipes, brown bowel observed on cleansing wipe. NA-A removed her gloves from both hands, immediately reach out to adjust R15's incontinent brief and pants and immediately transferred R15 into a recliner in the room.	21385		

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21385	Continued From page 4 -at 12:51 p.m. NA-A reached out, placed both hands on the mechanical lift and pushed the mechanical lift out of the doorway and hallway, to a alcove in the facility hallway. NA-A had not washed her hands or performed hand hygiene during the entire observation. During interview on 8/12/15, at 12:51 p.m. NA-A confirmed cares were complete for R15, and confirmed she had not sanitized or washed her hands after providing cares to R15. NA-A stated, "you caught me off guard." NA-A confirmed normal practice would be to wash or use hand sanitizer after removing gloves. NA-A reported housekeeping staff cleaned the mechanical lifts daily, and indicated nursing staff should wipe off the mechanical lifts with bleach wipes after each time a resident uses them. NA-A confirmed R15 had used the lift handle while holding it with a soiled tissue, then stated it should have been sanitized with a bleach wipe. NA-A reported it is not nursing staff's usual protocol to clean the lifts between each resident use, and did confirms facility mechanical lifts were equipped with sanitizing wipes in bags attached to the mechanical lifts. During interview on 8/13/15, at 4:30 p.m. staff development coordinator confirmed a soiled tissue would warrant a mechanical lift disinfecting between resident use, and stated nursing staff were expected to disinfect the mechanical lifts in between resident uses. Further, the staff development coordinator confirmed all staff were expected to wash hands when visibly soiled after any kind of resident care, and were expected to perform hand hygiene/ sanitize when going in and out of resident rooms.	21385		

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21385	Continued From page 5 During interview on 8/14/15, at 1:09 p.m. the director of housekeeping stated the housekeeping staff cleaned all of the mechanical lifts daily, however, nursing staff were expected to also clean the lifts as needed after resident use. The director of housekeeping stated the lifts were equipped with disinfectant wipes in the tubs attached to the mechanical lifts. During interview on 8/14/15, at 1:18 p.m. the director of nursing(DON) stated all staff were expected to wash and/or sanitize hands after removing gloves and before touching another surface. The DON reported the facility directed staff to keep hand sanitizer in their pockets for that purpose. The DON confirmed nursing staff were to wipe down all mechanical lifts with bleach wipes between resident uses if the lift becomes contaminated, and verified all nursing staff were educated regarding the requirement. The facility's Hand Hygiene and Handwashing Policy dated 6/14, directed staff to perform hand hygiene after removing gloves. SUGGESTED METHOD OF CORRECTION: The DON or infection control officer could develop could educate staff on the infection control program along with random audits of staff cares to ensure proper techniques are implemented. The infection control program could be integrated with the quality assurance program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		

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21426	Continued From page 6	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all health care workers received timely baseline tuberculosis(TB) symptom screening and timely two-step tuberculin skin test(TST)for 2 out of 5 employees reviewed. Findings include: Employee (E)- A, had been hired by the facility on 2/13/15. A tuberculin symptom screening had been completed on 9/11/14, a total of 5 months and 2 days prior to hire. E-A had received the first step TST on 9/23/14 and the 2nd step on 10/1/14,	21426	Corrected	9/25/15

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21426	Continued From page 7	21426		

a total of 4 months and 13 days prior to hire.
E -B had been hired by the facility on 4/2/15, had received the 1st step TST on 12/22/14 and the 2nd step TST on 12/31/14, a total of 4 months and 2 days prior to hire. The personnel record lacked documentation of a TB symptom screening completed for E-B.
On 8/13/14, at approximately 8:30 a.m., the assistant director of nursing (ADON) stated she accepted the tuberculin screening and Mantoux (TST) information from the employee's previous employers and had felt that was adequate. ADON verified E -A and E- B should have had the 2 step mantoux (TST) and tuberculosis screening repeated when hired by the facility.
On 8/14/15 at 9:55 a.m. the director of nursing (DON) stated employees should have Mantoux screening and mantouxs (TST) given before employees start in the facility, regardless if they had it done previously.
Review of the policy titled, Tuberculin Control Plan For Healthcare Workers, dated 6/2012, indicated new employees will have baseline TB screening completed utilizing the tuberculin skin test (TST) two step method, unless contraindicated. In addition, new employees with verified TST results not more than 30 days old (or per state regulation) will not be retested.
Review of the policy titled, Tuberculin Skin Testing revised on 8/14, indicated the employee will have baseline screening using the TST 2 step method. This involved administrating the initial TST and it is to be read in 48 to 72 hours by nursing personnel or physician and the 2nd step to be completed in 1 to 2 weeks.
A policy for symtpom screening was requested, the facility did not provide a copy.
Suggested method of correction: The director of nursing /designee could develop a process to ensure that health care workers receive a

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21426	Continued From page 8 baseline screening for symptoms of TB and a two-step mantoux. TIME PERIOD FOR CORRECTION: FOURTEEN (14) DAYS	21426		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA) and failed to complete a thorough investigation for 2 of 2 residents (R15, R3) for injuries of unknown origin and potential neglect of care, reviewed for abuse prohibition. Findings include:	21990	Corrected	9/25/15

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21990	Continued From page 9 R15's injury of unknown origin was not reported to the SA and thoroughly investigated. R15's quarterly MDS dated 7/21/15, identified R15 had diagnoses which included dementia, delusional disorder, depression, and anxiety. The MDS identified R15 had moderately impaired cognitive skills for daily decision making and both short-term and long-term memory problems. Further, the MDS identified R15 required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. Review of R15's care plan dated 3/31/15, revealed R15 had impaired cognition function relation to CVA, delirium and confusion. The care plan indicated R15 would forget cares just completed by staff, was difficult to re-direct, had poor judgement with decisions resulting in needing assistance with decisions and verbalizations. Review of R15's incident report dated, 4/12/15, revealed staff had heard an alarm and found R15 on the floor in the bathroom doorway. The report described R15 lying with his head next to the bathroom doorway, and R15 reported he was going to the bathroom. The report identified R15 had impaired memory, impaired vision, and drowsiness. Further, the report identified no witnesses were found of the incident and listed R15 had multiple skin tears and was bleeding from the right temple and left inner forearm and did not report pain. Review of R15's progress notes dated 4/12/15 revealed the following:	21990		

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21990	Continued From page 10	21990		

-4:30 a.m., nursing assistant found R15 lying on the floor in front of the bathroom doorway. R15 had bleeding at the temple, and multiple skin tears. R15 had been assisted from the floor into bed by facility staff and a mechanical lift device.

-6:10 a.m., when assisted to ambulate, R15 could not bear full weight on the right leg and right leg was slightly turned outward. R15 complained of dizziness, pain and had a small emesis. The note indicated R15 had been transferred to the hospital for evaluation on 4/12/15 at 7:45 a.m., at 10:00 a.m. the facility was contacted to confirm R15's hip fracture and would require surgical repair of the hip fracture.

During interview on 08/13/15 at 11:24 a.m., trained medication aide (TMA)-A-reported R15 had very poor memory and had a difficult time concentrating or recalling past events.

During interview on 8/13/15 at 4:59 p.m., registered nurse (RN)-A stated R15 had dementia, poor memory recall and required redirection. RN-A stated R15 developed pain after the 4/12/15 fall, was sent to the hospital for evaluation and had been diagnosed with fractured hip which required surgical repair. RN-A confirmed R15's fall was not witnessed by any staff, confirmed the facility had assumed R15 fell. RN-A stated she has never viewed this as an injury of unknown origin, even though R15 has dementia with poor memory, and was diagnosed with significant injury.

During interview on 08/13/15 at 11:28 a.m., the DON confirmed R15 had an unwitnessed fall on 4/12/15 and was found on floor with walker in bathroom doorway. The DON reported R15's cognition fluctuated and confirmed R15 was not a

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21990	Continued From page 11 reliable source for information. The DON stated the facility had not previously taken into consideration the reporting requirement regarding unexplainable injuries of unknown source with cognitively impaired residents. The DON confirmed R15's incident lacked a thorough investigation. SUGGESTED METHOD FOR CORRECTION: The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all reports of abuse are being reported and investigated. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken	22000		9/25/15

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22000	Continued From page 12 to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.	22000		

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22000	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse and neglect policy and procedures related to immediatel notification to the state agency (SA) and conduct a thorough investigation for 2 of 2 residents (R15, R3) reviewed for abuse prohibition with significant injuries of unknown origin and potential neglect of care. Findings include: Review of facility policy titled, Abuse And Neglect, revised on 9/13, directed staff to report alleged or suspected violations involving any mistreatment, neglect, abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency. The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Review of the decision tool provided by the facility titled MN Nursing Home Decision Tool to Determine Potential Reportability and Facility Follow Up Process for Resident to Resident Altercation dated 6/13, identified situations when an incident was reportable to the SA. In addition, the form identified the tool should be used in conjunction with applicable federal nursing home regulations and is not intended to replace professional judgement or legal advice. Review of the decision tool provided by the facility	22000	Corrected	

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	00146	A. BUILDING: _____ B. WING _____	08/14/2015

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22000	Continued From page 14 titled Federal Long Term Care Reportablity for Injures of Unknown Source under F225 form , dated 5/13 identified situations when an incident was reportable to the SA. In addition, the form identified the tool was optional, if used, this tool is to be used in conjunction with applicable Federal Nursing Home regulations. Causes of injuries may also be reportable as mistreatment, abuse, or neglect. R15's injury of unknown origin was not reported to the SA and thoroughly investigated. R15's quarterly MDS dated 7/21/15, identified R15 had diagnoses which included dementia, delusional disorder, depression, and anxiety. The MDS identified R15 had moderately impaired cognitive skills for daily decision making and both short-term and long-term memory problems. Further, the MDS identified R15 required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. Review of R15's care plan dated 3/31/15, revealed R15 had impaired cognition function relation to CVA, delirium and confusion. The care plan indicated R15 would forget cares just completed by staff, was difficult to re-direct, had poor judgement with decisions resulting in needing assistance with decisions and verbalizations. Review of R15's incident report dated, 4/12/15, revealed staff had heard an alarm and found R15 on the floor in the bathroom doorway. The report described R15 lying with his head next to the bathroom doorway, and R15 reported he was going to the bathroom. The report identified R15	22000		

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22000	Continued From page 15	22000		

had impaired memory, impaired vision, and drowsiness. Further, the report identified no witnesses were found of the incident and listed R15 had multiple skin tears and was bleeding from the right temple and left inner forearm and did not report pain.

Review of R15's progress notes dated 4/12/15 revealed the following:

-4:30 a.m., nursing assistant found R15 lying on the floor in front of the bathroom doorway. R15 had bleeding at the temple, and multiple skin tears. R15 had been assisted from the floor into bed by facility staff and a mechanical lift device.

-6:10 a.m., when assisted to ambulate, R15 could not bear full weight on the right leg and right leg was slightly turned outward. R15 complained of dizziness, pain and had a small emesis. The note indicated R15 had been transferred to the hospital for evaluation on 4/12/15 at 7:45 a.m., at 10:00 a.m. the facility was contacted to confirm R15's hip fracture and would require surgical repair of the hip fracture.

During interview on 08/13/15 at 11:24 a.m., trained medication aide (TMA)-A-reported R15 had very poor memory and had a difficult time concentrating or recalling past events.

During interview on 8/13/15 at 4:59 p.m., registered nurse (RN)-A stated R15 had dementia, poor memory recall and required redirection. RN-A stated R15 developed pain after the 4/12/15 fall, was sent to the hospital for evaluation and had been diagnosed with fractured hip which required surgical repair. RN-A confirmed R15's fall was not witnessed by any staff, confirmed the facility had assumed R15

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22000	Continued From page 16 fell. RN-A stated she has never viewed this as an injury of unknown origin, even though R15 has dementia with poor memory, and was diagnosed with significant injury. During interview on 08/13/15 at 11:28 a.m., the DON confirmed R15 had an unwitnessed fall on 4/12/15 and was found on floor with walker in bathroom doorway. The DON reported R15's cognition fluctuated and confirmed R15 was not a reliable source for information. The DON stated the facility had not previously taken into consideration the reporting requirement regarding unexplainable injuries of unknown source with cognitively impaired residents. The DON confirmed R15's incident lacked a thorough investigation. R3's injury of unknown origin and potential neglect of care was not reported to the SA and thoroughly investigated. R3's significant change MDS dated 4/29/15 identified R3 had diagnoses which included arthritis, osteoporosis, and dementia. Further, the MDS identified R3 had severe cognitive impairment and required extensive assistance with all activities of daily living. Review of R3's incident report, dated 4/26/15, revealed R3 was found lying on her back on the floor in her room. R3 had hollered out in pain and held her chest area when staff attempted to move her. The report identified R3 had an abrasion to the face and a bruise on the back of the right hand. The report identified there were no witnesses found and R3 did not remember falling 15 minutes after episode due to confusion,	22000		

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22000	Continued From page 17 impaired memory and gait imbalance. Review of R3's progress notes from 4/26/15 to 4/28/15 revealed the following: -On 4/26/15, at 2:57 p.m. R3 was found lying on her back on the floor of her room. Noted to have a abrasion on forehead with no drainage, with slight swelling in area. R3 stated she had been on her way to the bathroom, and indicated she did not remember falling. R3 hollered out in pain when attempted to move and indicated her mid chest area hurt. R3's left side of chest was noted to be more elevated then right side and an ice pack was applied to chest area & forehead. Further, the progress note identified at 11:15a.m. R3 was observed to holler out in pain and hold chest area when staff attempted to provide cares. R3 had rapid respirations and low oxygen levels at that time, and administration of oxygen (O2) was attempted. Call placed again to Dr. for Morphine order for residents comfort, staff has been unable to assist resident due to pain, also requested prn O2 order if resident needed. -On 4/28/15, at 2:02 p.m. DON identified R3 had a fall with injury on 4/26/15. Now has sensor alarm pad while in bed as resident requires assist with transfers and ambulation due to increased pain to chest. Staff continue to work closely with MD related to morphine use and suspected injury to sternum. Family agreed resident should stay within the confines of the nursing home for resident comfort and well-being. During interview on 8/13/14 at 4:25 p.m. the administrator confirmed the current facility policy and indicated the facility policy included decision	22000		

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22000	Continued From page 18 trees which staff utilized to determine when to report to the SA. He indicated the usual facility practice was to immediately report to the SA injuries of unknown origin, resident to resident altercation, and falls which resulted in fractures. The administrator stated "we should be following the written policy." He indicated the facility may not be interpreting the tools appropriately. On 08/14/15, at 9:05 a.m. during interview the DON reviewed incident on 4/26/15. She stated R3 took herself to the bathroom and fell. She stated, "We know she took herself to bathroom, because she didn't take any staff with her, and that's what she told us happened." She stated they suspected a significant injury happened at that time because of R3's chest pain and holding her chest. She stated the facility had not reported the incident because R3's care plan was followed, and stated that was what the staff looked at to determine if it was reportable or not. She stated the incident had not been reported to the SA because R3's care plan was followed. She stated R3 did not get medical treatment because it is difficult to get her to eat or shower, and because she was very paranoid related to her disease process. She stated for the facility to transport R3 to the hospital it would be more traumatizing, and they likely would not have done anything for her suspected injury, and that's why there was nothing done. SUGGESTED METHOD FOR CORRECTION: The Director of Nurses and the Social Worker could provide additional education to all staff regarding reporting responsibilities and immediate investigation to ensure implementation of the procedures of the facility's Abuse	22000		

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22000	Continued From page 19 Prevention Policy. The quality assurance program could randomly audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		