DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	MQKK
Fac	lity ID: 00146

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MEDICARE/MEDICAID PROVID (L1) 245403 2.STATE VENDOR OR MEDICAID I		3. NAME AND AL (L3) GOOD SAM (L4) 105 GLENH	IARITAN SO	CIETY - BA	ATTLE LAKE	4. TYPE OF ACTIO	2. Recertification
(L2) 150518100	10 .	(L5) BATTLE LA		_	(L6) 56515	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEO	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Afte	9. Other
6. DATE OF SURVEY 09/29 8. ACCREDITATION STATUS: 0 Unaccredited 1 TIC 2 AOA 3 Other	0/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END:	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		X A. In Complian	nce With		And/Or Approved Waivers O	The Following Requiren	nents:
To (b):			equirements e Based On:		2. Technical Personne 3. 24 Hour RN	6. Scope of So 7. Medical Di	
12.Total Facility Beds	55 (L18)	•	cceptable POC				om Size
13.Total Certified Beds	55 (L17)		npliance with Prog ents and/or Appli			(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 55	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Gail Anderson, Unit	Supervisor	1	0/07/2015	(L19)	Mark Meath	, Enforcement Spec	ialist 10/07/2015 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBII	LITY		IPLIANCE WITI	H CIVIL	21. 1. Statement of Fina 2. Ownership/Contr	uncial Solvency (HCFA-25 rol Interest Disclosure Stm	
X 1. Facility is Eligible to	Participate	Rioi	maner.		3. Both of the Abov		(Herri 1313)
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNING	B DATE	ENDING DA	TE	VOLUNTARY 0		
12/01/1986					01-Merger, Closure 02-Dissatisfaction W/ Reimburs		Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminati	on	Meet Agreement
25. LTC EXTENSION DATE:		VE SANCTIONS			04-Other Reason for Withdrawal	OTHER	ler Status Change
	A. Suspension	n of Admissions:	(L44)			00-Active	-
(L27)	B. Rescind St	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00140					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)	09/24/2015		(L33)	DETERMINATION APP	ROVAL	



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 Weath

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



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

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 245403	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/29/2015
Name	of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - BATTLE LAKE		AKE	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	i) Date	(Y4) Item	(Y5) Date	(Y4)	Item	1	(Y5)	Date
ID Prefix	F0225	Correction Completed 09/25/2015	ID Prefix	F0226	Correction Completed 09/25/2015		ID Prefix	F0441		Correction Completed 09/25/2015
	483.13(c)(1)(ii)-(iii), (c)(2)	_		483.13(c)	_			483.65		
LSC	403.13(0)(1)(1)-(11), (0)(2)		LSC	400.13(c)	_		LSC	403.03		_
		_				+-				_
		Correction			Correction					Correction
10 D C		Completed	10.0 6		Completed		ID D . C			Completed
ID Prefix		_	ID Prefix	-	_		ID Prefix			_
Reg. # LSC		_	Reg. #		_		Reg. #			_
		_	100			+-				_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix		_		ID Prefix			_
Reg. #		_	Reg. #				Reg. #			_
LSC		_	LSC		_	<u> </u>	LSC			_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		•	ID Prefix				ID Prefix			_
Reg. #		_	Reg. #		_		Reg. #			_
LSC		_	LSC		_		LSC			_
		0			O a mana atti a m					0
		Correction Completed			Correction Completed					Correction Completed
ID Prefix			ID Prefix				ID Prefix			
Reg. #			Reg. #				Reg. #			
LSC			LSC		_		LSC			_
Reviewed By	Reviewed GA/mi		Date: 10/07/20	Signature of Surv	eyor: 2800	3/1			Date:	0/0045
State Agency		11	10/01/20			U -1			09/2	9/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Surv	eyor:				Date:	
CMS RO										
Followup to	Survey Completed on:				y Uncorrected [_		
	8/14/2015			Uncorrect	ed Deficiencies	(CMS	-2567) Sent	to the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1)	Provider / Supplier / CLIA / Identification Number 245403	(Y2) Multiple Constru A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 10/2/2015
Name	of Facility		Street Address, City, State, Zip Code	
GC	OOD SAMARITAN SOCIETY - BATTLE LA	KE	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
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			08/24/2015		ID Prefix			09/18/2015		ID Prefix			09/30/2015
•	NFPA 101				•	NFPA 101				-	NFPA 101		_
LSC	K0046			_	LSC	K0047				LSC	K0056		_
			Correction					Correction					Correction
ID Prefix			Completed 08/20/2015		ID Prefix			Completed 09/24/2015		ID Prefix			Completed 08/20/2015
Rea.#	NFPA 101		=			NFPA 101		=			NFPA 101		_
-	K0062				-	K0067		•		_	K0073		_
				 									
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			09/17/2015		ID Prefix			-		ID Prefix			_
•	NFPA 101				Reg. #					Reg. #			_
LSC	K0144			<u> </u>	LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #					Reg. #			_
LSC													_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix			-		ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
Reviewed By		Reviewed I	Зу	Da	te:	Signatur	e of Surve	yor:				Date:	
State Agency	<u> </u>	GS/mm	1	1	0/07/20	1			272	00		10/02	2/2015
Reviewed By		Reviewed E	Зу	Da	te:	Signatur	e of Surve	yor:				Date:	
CMS RO													
Followup to	Survey Compl	eted on:				Che	ck for any	Uncorrected	Defi	ciencies. Was	a Summary of	-	
	8/17/	2015					-				to the Facility?	YES	NO

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 245403	(Y2) Multiple Constru A. Building B. Wing	CONNECTING LINK	(Y3) Date of Revisit 10/2/2015
Name	of Facility		Street Address, City, State, Zip Code	
GC	OOD SAMARITAN SOCIETY - BATTLE LA	KF	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
			Correction						Correction					Correction
			Completed						Completed					Completed
ID Prefix			08/20/2015		ID Prefix				08/20/2015		ID Prefix			09/24/2015
Reg. #	NFPA 101				Reg. #	NFPA '	101				-	NFPA 101		_
LSC	K0056				LSC	K0062					LSC	K0067		_
										Τ.				
			Correction						Correction					Correction
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ID Prefix			08/20/2015		ID Prefix				09/17/2015					
-	NFPA 101				-	NFPA '					Reg. #			_
LSC	K0073				LSC	K0144				Щ.	LSC			_
			Correction						Correction					Correction
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			Correction						Correction					Correction
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ID Prefix			•		ID Prefix						ID Prefix			_
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LSC					LSC						LSC			-
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			Correction						Correction					Correction
			Completed						Completed					Completed
ID Prefix			-		ID Prefix						ID Prefix			_
Reg. #					Reg. #						Reg. #			_
LSC					LSC						LSC			_
Reviewed By	·	Reviewed B	Зу	Da	ite:		Signature of	f Surve	yor:				Date:	
State Agency	y	GS/mn	n	_	10/07/20	015			27	200)		10/0	2/2015
Reviewed By	,	Reviewed E	Зу	Da	ite:		Signature of	f Surve	yor:				Date:	
CMS RO														
Followup to	Survey Compl	eted on:					Check f	for anv	Uncorrected	Defic	iencies. Was	a Summary of	-	
	8/17/	2015						-				to the Facility?	YES	NO
				1										

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: MQKK

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COMI	PLETED BY T	HE STAT	E STATE SURVEY AGENCY Facility ID: 00146			
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245403 2.STATE VENDOR OR MEDICAID NO. (L2) 150518100		3. NAME AND ADD (L3) GOOD SAMA (L4) 105 GLENHA (L5) BATTLE LAI	ARITAN SOCIE AVEN DRIVE			(L6) 56515	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	ON: <u>2 (L8)</u> 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNE (L9)		7. PROVIDER/SUP	05 HHA	09 ESRD	13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other ter Complaint
6. DATE OF SURVEY 08/14/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAL YEAR END	DING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	55 (L18) 55 (L17)	A. In Compliand Program Red Compliance1. As X B. Not in Comp	A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers:			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 * Code: B* (L12)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 55	19 SNF	ICF	IID		15. FACILIT	Y MEETS 1) or 1861 (j) (1):	(L15)	
(L37) (L38) (L39) (L42) (L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):								
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVEY AGENCY AP		Date:
Christina Martinson			09/14/2015	(L19)		Enforcement	Specialist	09/16/2015 (L20)
	PART II - TO	BE COMPLETEI	D BY HCFA RI	EGIONAL	OFFICE C	OR SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate to Parti	pate		PLIANCE WITH C	CIVIL	 21. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24)	23. LTC AGREEMI BEGINNING (L41)		4. LTC AGREEME ENDING DATE (L25)		VOLUNTAI 01-Merger, 0		05-Fail	(L30) <u>JUNTARY</u> to Meet Health/Safety to Meet Agreement
	27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L44)			nvoluntary Termination ason for Withdrawal	OTHEI 07-Pro 00-Act	vider Status Change
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/Ca	AKRIEK NO.		30. REMAR	KKS		
	(L28)	00140		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION O	OF APPROVAL DA	ГЕ				
	(L32)			(L33)	DETERM	IINATION APPRO	VAL	



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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_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

PRINTED: 09/14/2015 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245403	B. WING		08/14/2015
	ROVIDER OR SUPPLIER MARITAN SOCIETY - B	ATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 000		f correction (POC) will serve	F 00	0	
	Department's accep enrolled in ePOC, yo at the bottom of the form. Your electroni be used as verification. Upon receipt of an a on-site revisit of you validate that substar regulations has been	f compliance upon the tance. Because you are pur signature is not required first page of the CMS-2567 ic submission of the POC will on of compliance. Acceptable electronic POC, an ir facility may be conducted to intial compliance with the in attained in accordance with			
F 225 SS=D	INVESTIGATE/REP ALLEGATIONS/IND The facility must not been found guilty of mistreating residents had a finding entere registry concerning a of residents or misal and report any know court of law against indicate unfitness fo other facility staff to or licensing authoriti	ORT IVIDUALS employ individuals who have abusing, neglecting, or s by a court of law; or have d into the State nurse aide abuse, neglect, mistreatment ppropriation of their property; vledge it has of actions by a an employee, which would r service as a nurse aide or the State nurse aide registry	F 22	5	9/25/15
LABORATORY	involving mistreatme including injuries of a misappropriation of immediately to the a to other officials in a through established State survey and ce	ent, neglect, or abuse, unknown source and resident property are reported idministrator of the facility and ccordance with State law procedures (including to the	RF.	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

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 A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245403	B. WING		08/14/2015		
	ROVIDER OR SUPPLIER MARITAN SOCIETY - E	BATTLE LAKE	1	STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
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F 225	Continued From pa		F 225				
	violations are thoro	ve evidence that all alleged ughly investigated, and must ential abuse while the rogress.					
	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						
				Incidents for R15 and R3 have been reported to OHFC per facility policy are procedure. A subsequent investigation report has been filed for each of the incidents reported.	nd		
				 All residents within the facility are identified as having the potential to be affected by this same deficient practic All incident reports will be reviewed by DON, SS, and administrator to ensure compliance with the facility abuse prevention plan. The administrator, DON, social woor designee will review and revise, as necessary, internal processes of 	e. v the v rker,		
	Further, the MDS ic	-term memory problems. lentified R15 required le of one staff for bed mobility, toileting, personal hygiene		reporting/investigating abuse, neglect, resident to resident altercations. The DON, social worker or designee provideducation to nursing staff on 8/26/15 and the staff of the	ded		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245403	B. WING			8/14/2015	
	ROVIDER OR SUPPLIER MARITAN SOCIETY - BA	TTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
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F 225	and bathing. Review of R15's care revealed R15 had im relation to CVA, deliriplan indicated R15 w completed by staff, w poor judgement with needing assistance w verbalizations. Review of R15's incide revealed staff had he on the floor in the bath described R15 lying whathroom doorway, a going to the bathroom had impaired memory drowsiness. Further, witnesses were found R15 had multiple skir from the right temple did not report pain. Review of R15's progrevealed the following at the floor in front of the had bleeding at the tears. R15 had been bed by facility staff ar -6:10 a.m., when ass could not bear full we leg was slightly turne of dizziness, pain and note indicated R15 had series and respectively.	e plan dated 3/31/15, paired cognition function um and confusion. The care ould forget cares just ras difficult to re-direct, had decisions resulting in with decisions and dent report dated, 4/12/15, ard an alarm and found R15 chroom doorway. The report with his head next to the and R15 reported he was an. The report identified R15 by, impaired vision, and the report identified no d of the incident and listed an tears and was bleeding and left inner forearm and	F 2:	9/1/15 on the facility policy a related to the abuse prevent Staff will continue to be edu practice upon hire. 4. To monitor performance responsibilities of reporting incident reports will be audit or designee x4 weeks, and x3. All audit findings will be monthly QA meeting for furt recommendation. 5. Completion Date: Septer	tion plan. cated on this related to the to the SA, all ted by the DNS then randomly reported to the her		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		DNSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
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F 225	10:00 a.m. the facility R15's hip fracture and repair of the hip fracture and repair of the hip fracture. During interview on 00 trained medication aid had very poor memory concentrating or recard During interview on 80 registered nurse (RN dementia, poor memory redirection. RN-A state after the 4/12/15 fall, evaluation and had be hip which required succonfirmed R15's fall was taff, confirmed the facility of unknown dementia with poor mowith significant injury. During interview on 00 DON confirmed R15 4/12/15 and was fou bathroom doorway. Cognition fluctuated a reliable source for infinithe facility had not proconsideration the repunexplainable injuries cognitively impaired results.	was contacted to confirm d would require surgical ure. 8/13/15 at 11:24 a.m., de (TMA)-A-reported R15 ry and had a difficult time lling past events. /13/15 at 4:59 p.m., and a difficult time lling past events. /13/15 at 4:59 p.m., and a difficult time lling past events. /13/15 at 4:59 p.m., and a difficult time ling past events. /13/15 at 4:59 p.m., and a difficult time ling past events. /13/15 at 4:59 p.m., and a difficult time ling past events. /13/15 at 4:59 p.m., and a difficult time ling ling past events. /13/15 at 4:59 p.m., and was event ling ling ling ling ling ling ling ling	F2	225				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED					
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F 225	Continued From pag	e 4	F 2	25				
	neglect of care was r thoroughly investigat R3's significant chan identified R3 had dia arthritis, osteoporosis MDS identified R3 ha	ge MDS dated 4/29/15 gnoses which included s, and dementia. Further, the ld severe cognitive						
	Review of R3's incide revealed R3 was four floor in her room. R3 held her chest area wher. The report identices	ent report, dated 4/26/15, and lying on her back on the had hollered out in pain and when staff attempted to move fied R3 had an abrasion to on the back of the right						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		245403	B. WING _			08/14/2015
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F 225	witnesses found and 15 minutes after episimpaired memory and Review of R3's progre 4/28/15 revealed the -On 4/26/15, at 2:57 her back on the floor a abrasion on foreheaslight swelling in area her way to the bathro not remember falling, when attempted to mothest area hurt. R3's to be more elevated to pack was applied to concept a supplied to concept and administration or the start and ampain to chest. Staff con MD related to morphilipair and start and ampain to chest. Staff con MD related to morphilipair and start and ampain to chest. Staff con MD related to morphilipair and start	R3 did not remember falling ode due to confusion, digait imbalance. ess notes from 4/26/15 to following: p.m. R3 was found lying on of her room. Noted to have ad with no drainage, with a. R3 stated she had been on om, and indicated she did R3 hollered out in pain ove and indicated her mid left side of chest was noted hen right side and an ice chest area & forehead. Is note identified at 11:15a.m. holler out in pain and hold f attempted to provide cares. ions and low oxygen levels inistration of oxygen (O2) blaced again to Dr. for sidents comfort, staff has a resident due to pain, also ler if resident needed. D.m. DON identified R3 had 26/15. Now has sensor and as resident requires assist abulation due to increased ontinue to work closely with ne use and suspected injury greed resident should stay the nursing home for	F 2	25		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION		TE SURVEY MPLETED
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F 225	administrator confirmand indicated the fact trees which staff utilities report to the SA. He practice was to imminipries of unknown altercation, and falls. The administrator state written policy." Hot be interpreting the on 08/14/15, at 9:05 DON reviewed incide took herself to the beautiful take any sent to the beautiful take any sent to the beautiful take any sent to the beautiful take and stated that was determine if it was rethe incident because R3 and stated that was determine if it was rethe incident had not because R3's care process. She stated to the hospital it wouthey likely would not suspected injury, an nothing done. Review of facility porrevised on 9/13, directions.	8/13/14 at 4:25 p.m. the ned the current facility policy cility policy included decision zed to determine when to indicated the usual facility ediately report to the SA origin, resident to resident which resulted in fractures. ated "we should be following le indicated the facility may ne tools appropriately. 5 a.m. during interview the ent on 4/26/15. She stated R3 athroom and fell. She stated, nerself to bathroom, because staff with her, and that's what d." She stated they ant injury happened at that is chest pain and holding her e facility had not reported the est care plan was followed, what the staff looked at to exportable or not. She stated been reported to the SA olan was followed. She stated cal treatment because it is eat or shower, and because old related to her disease for the facility to transport R3 and have done anything for her d that's why there was	F 22	25		
	suspected violations	involving any mistreatment,				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	PLE CONSTRUCTION G	CTION (X3) DATE COMP	
		245403	B. WING _			8/14/2015
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F 225	administrator and to with state law, includ certification agency. evidence that all allegare thoroughly invest further potential abus progress. Review of the decision titled MN Nursing Ho Determine Potential I Follow Up Process for Altercation dated 6/1 an incident was report the form identified the conjunction with applications and is no professional judgement.	d immediately to the center other officials in accordance ing the state survey and The center will have ged or suspected violations igated and will prevent while the investigation is in on tool provided by the facility me Decision Tool to Reportability and Facility or Resident to Resident 3, identified situations when reable to the SA. In addition, we tool should be used in icable federal nursing home to intended to replace	F 2.	25		
F 226 SS=D	dated 5/13 identified was reportable to the identified the tool was to be used in conjunct Nursing Home regular may also be reportable or neglect. 483.13(c) DEVELOP ABUSE/NEGLECT, ETHE facility must developlicies and procedu	situations when an incident SA. In addition, the form soptional, if used, this tool is cition with applicable Federal ations. Causes of injuries as mistreatment, abuse, //MPLMENT ETC POLICIES elop and implement written res that prohibit t, and abuse of residents	F 2	26		9/25/15

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 226	Continued From pag	e 8	F 226			
	by: Based on interview facility failed to imple neglect policy and primmediatel notification and conduct a thorous residents (R15, R3) prohibition with signiorigin and potential residency origin and potential residency origin and potential residency origin will be reported administrator and to with state law, included certification agency, evidence that all alles are thoroughly investigation or the decision of	on to the state agency (SA) ugh investigation for 2 of 2 reviewed for abuse ficant injuries of unknown neglect of care. icy titled, Abuse And Neglect, octed staff to report alleged or involving any mistreatment, ding injuries of unknown d immediately to the center other officials in accordance ling the state survey and The center will have ged or suspected violations tigated and will prevent se while the investigation is in on tool provided by the facility one Decision Tool to Reportability and Facility or Resident to Resident 3, identified situations when ortable to the SA. In addition, te tool should be used in licable federal nursing home		 Incidents for R15 and R3 have be reported to OHFC per facility policy a procedure. A subsequent investigating report has been filed for each of the incidents reported. All residents within the facility are identified as having the potential to be affected by this same deficient practing. All incident reports will be reviewed to DON, SS, and administrator to ensurcompliance with the facility abuse prevention plan. The administrator, DON, social woor designee will review and revise, an necessary, internal processes of reporting/investigating abuse, neglect resident to resident altercations. The DON, social worker or designee proveducation to nursing staff on 8/26/15 9/1/15 on the facility policy and proceducated to the abuse prevention plant. Staff will continue to be educated on practice upon hire. To monitor performance related to responsibilities of reporting to the SA incident reports will be audited by the or designee x4 weeks, an then mont x3. All audit findings will be reported monthly QA meeting for further recommendation. 	e ce. by the e ce. ct, and e vided and edure this	
	regulations and is no professional judgem	ot intended to replace		5. Completion Date: September 25.	2015	

AND DUAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245403	B. WING		08/14/2015		
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F 226	titled Federal Long Injures of Unknown dated 5/13 identified was reportable to the identified the tool was to be used in conju Nursing Home regumay also be reported or neglect. R15's injury of unknown to the SA and thored R15's quarterly MD R15 had diagnoses delusional disorder MDS identified R15 cognitive skills for a short-term and long Further, the MDS identified R15 cognitive assistant transfers, dressing, and bathing. Review of R15's carevealed R15 had i relation to CVA, desired to the same statement of the same shows	sion tool provided by the facility Term Care Reportablity for Source under F225 form, d situations when an incident ne SA. In addition, the form as optional, if used, this tool is nction with applicable Federal ulations. Causes of injuries able as mistreatment, abuse,	F 226				
	poor judgement wit needing assistance verbalizations. Review of R15's indevealed staff had h	was difficult to re-direct, had h decisions resulting in with decisions and cident report dated, 4/12/15, heard an alarm and found R15 hathroom doorway. The report					

	IENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED			
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F 226	bathroom doorway, going to the bathroom had impaired memor drowsiness. Further witnesses were fou R15 had multiple sk from the right templ did not report pain. Review of R15's prorevealed the following the floor in front of the had bleeding at the tears. R15 had been been by facility staff. -6:10 a.m., when as could not bear full vieg was slightly turn of dizziness, pain a note indicated R15 hospital for evaluating 10:00 a.m. the facility R15's hip fracture as repair of the hip fracture and very poor memor concentrating or reconcentrating or reconcentrating or memoredirection. RN-A staff.	g with his head next to the and R15 reported he was om. The report identified R15 ory, impaired vision, and r, the report identified no and of the incident and listed kin tears and was bleeding e and left inner forearm and ogress notes dated 4/12/15 ng: assistant found R15 lying on the bathroom doorway. R15 temple, and multiple skin assisted from the floor into and a mechanical lift device. sisted to ambulate, R15 weight on the right leg and right led outward. R15 complained and had a small emesis. The had been transferred to the on on 4/12/15 at 7:45 a.m., at ity was contacted to confirm and would require surgical cture. 08/13/15 at 11:24 a.m., aide (TMA)-A-reported R15 ory and had a difficult time	F 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245403	B. WING		08/14/2015		
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION		
F 226	evaluation and had hip which required s confirmed R15's fall staff, confirmed the fell. RN-A stated shan injury of unknow dementia with poor with significant injur. During interview on DON confirmed R15'd 4/12/15 and was for bathroom doorway. cognition fluctuated reliable source for in the facility had not proconsideration the reunexplainable injuric cognitively impaired confirmed R15's indinvestigation. R3's injury of unknown eglect of care was thoroughly investigation. R3's significant chaid identified R3 had diarthritis, osteoporos MDS identified R3 had diarthritis, osteoporos MDS identified R3 had diarthritis of the revealed R3 was for floor in her room. R held her chest area	been diagnosed with fractured surgical repair. RN-A was not witnessed by any facility had assumed R15 he has never viewed this as norigin, even though R15 has memory, and was diagnosed y. 08/13/15 at 11:28 a.m., the had an unwitnessed fall on fund on floor with walker in The DON reported R15's and confirmed R15 was not a anformation. The DON stated previously taken into reporting requirement regarding residents. The DON sident lacked a thorough form origin and potential not reported to the SA and atted. Inge MDS dated 4/29/15 agnoses which included his, and dementia. Further, the had severe cognitive uired extensive assistance	F 226				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		ATE SURVEY DMPLETED	
		245403	B. WING			08/14/2015	
	ROVIDER OR SUPPLIER MARITAN SOCIETY - E	BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 226	hand. The report ide witnesses found an 15 minutes after ep impaired memory a Review of R3's prog 4/28/15 revealed th -On 4/26/15, at 2:5 her back on the floor a abrasion on foreh slight swelling in archer way to the bath not remember fallin when attempted to chest area hurt. R3' to be more elevated pack was applied to Further, the progre R3 was observed to chest area when sta R3 had rapid respirat that time, and ad was attempted. Cal Morphine order for been unable to assirequested prn O2 or -On 4/28/15, at 2:02 a fall with injury on alarm pad while in twith transfers and a pain to chest. Staff MD related to morp to sternum. Family started and the started progression of the started progr	ee on the back of the right entified there were no d R3 did not remember falling isode due to confusion, and gait imbalance. Gress notes from 4/26/15 to e following: 7 p.m. R3 was found lying on or of her room. Noted to have ead with no drainage, with ea. R3 stated she had been on room, and indicated she did g. R3 hollered out in pain move and indicated her mid is left side of chest was noted if then right side and an ice or chest area & forehead. Ss note identified at 11:15a.m. or holler out in pain and hold aff attempted to provide cares ations and low oxygen levels ministration of oxygen (O2) Il placed again to Dr. for residents comfort, staff has ist resident due to pain, also rater if resident needed. 2 p.m. DON identified R3 had 4/26/15. Now has sensor over as resident requires assist imbulation due to increased continue to work closely with hine use and suspected injury agreed resident should stay of the nursing home for	F 22	26			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245403	B. WING			08/	14/2015
	ROVIDER OR SUPPLIER MARITAN SOCIETY - BA	ATTLE LAKE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 05 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)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 226	Continued From page	e 13	F	226			
	administrator confirm and indicated the fact trees which staff utilize report to the SA. He is practice was to immering injuries of unknown of altercation, and falls of the administrator state the written policy." He not be interpreting the On 08/14/15, at 9:05 DON reviewed incide took herself to the bas "We know she took herself to the bas where to didn't take any state told us happened suspected a significatime because of R3's chest. She stated the incident because R3' and stated that was we determine if it was rethe incident had not be because R3's care pl R3 did not get medicatificult to get her to eashe was very paranol process. She stated to the hospital it would stated the stated for the hospital it would be safe was very paranol process. She stated for the hospital it would be safe was very paranol process.	a.m. during interview the int on 4/26/15. She stated R3 throom and fell. She stated, erself to bathroom, because aff with her, and that's what d." She stated they int injury happened at that chest pain and holding her facility had not reported the scare plan was followed, what the staff looked at to portable or not. She stated been reported to the SA an was followed. She stated all treatment because it is eat or shower, and because id related to her disease for the facility to transport R3 d be more traumatizing, and have done anything for her					
F 441 SS=D	•	CONTROL, PREVENT	F	441			9/25/15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		245403	B. WING			08/	14/2015
	ROVIDER OR SUPPLIER	ATTLE LAKE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From pag	e 14	F.	441			
	Infection Control Prosafe, sanitary and control to help prevent the door disease and infection Control The facility must estate Program under which (1) Investigates, continuthe facility; (2) Decides what proshould be applied to (3) Maintains a recontactions related to infection (b) Preventing Spread (1) When the Infection determines that a respreyent the spread of isolate the resident. (2) The facility must communicable disease from direct contact will trading the facility must hands after each direct contact will trading the facility must hands after each direct contact will trading the facility must hands after each direct contact will trading the facility must hands after each direct contact will trading the facility must hands after each direct contact will trading the facility must hands after each direct contact will trading the facility must hands after each direct contact will trading the facility must hands after each direct contact will trading the facility must hand washing is indipersional practice.	Program ablish an Infection Control h it - trols, and prevents infections ocedures, such as isolation, an individual resident; and rd of incidents and corrective ections. ad of Infection on Control Program sident needs isolation to of infection, the facility must prohibit employees with a use or infected skin lesions with residents or their food, if insmit the disease. require staff to wash their ect resident contact for which cated by accepted					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245403	B. WING		08/14/2015	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BATTLE LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515	00/14/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 441	by: Based on observatireview, the facility fathandwashing technipersonal cares for 1 observed. In additional mechanical lift was for 1 of 1 resident (Findings include: R15's quarterly Mini 7/21/15, identified R included diabetes, of MDS identified R15 daily decision making and long term memory MDS identified requipersonal memory one staff for toileting During continuous of 12:40 p.m. to 12:54 (NA)-A was observed transfer from the whole with the staff of the staff of the staff of the staff of the staff onto the toilet and gloves from both had toilet, R15 started of tissue and handed to the staff of the staff	ion, interview and document ailed to ensure proper iques were followed during of 3 residents (R15) on, the facility failed to ensure s properly sanitized after use R15). imum Data Set (MDS) dated at 5 had diagnoses which dementia and anxiety. The moderately impaired skills for ing and had both short term ory problems. Further, the ired extensive assistance of	F 441	 Proper infection control practices being performed with all perineal care mechanical lift sanitation. All residents in this facility are at ribeing affected by this deficient practic infection control practices are not followed, education is provided immediately by the licensed staff. Staff education was provided relat proper hand washing and lift-cleaning procedure on 8/26/15 and 9/1/15. Nursing staff continue to be encouragt to carry hand sanitizer on their person wipes for lift sanitation are kept in bag each lift. Extra wipes are kept in nursistorage closet. DNS, infection control coordinator designee will perform random observational audits weekly x4 and monthly x3 on infection control practic related to perineal care and mechanic lift sanitation. All audit findings will be reported to the monthly QA meeting fourther recommendation. Completion Date: September 25, 201 	e and sk of ce. If ed to ged n; ges on sing or ces cal e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245403	B. WING _			8/14/2015		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BATTLE LAKE				STREET ADDRESS, CITY, STATE, ZIP CO 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 441	in his left hand while lift handle. -at 12:44 p.m. NA-A the mechanical lift to position and proceed area with a wet wipe barrier cream and restated he needed to immediately reached the lift in one hand, at the mechanical lift a onto the toilet. -at 12:46 p.m. NA-A proceeded to cleans wet wipes, brown bowipe. NA-A remove immediately reach obrief and pants and into a recliner in the rechanical lift out of a alcove in the facility. NA-A had not washed hand hygiene during. During interview on confirmed cares were confirmed she had reposition and parts and into a recliner in the same chanical lift out of a alcove in the facility.	e, then held the soiled tissue holding onto the mechanical applied fresh gloves, utilized assist R15 to a standing ded to cleanse R15's perineal e, removed one glove applied emoved the other glove. R15 use the toilet again, NA-A dout and held the controls for and placed the other hand on rm and lowered R15 back applied fresh gloves, and se R15's perineal area with owel observed on cleansing doubt her gloves from both hands, but to adjust R15's incontinent immediately transferred R15 room. Treached out, placed both anical lift and pushed the fithe doorway and hallway, to the dy hallway. The definition of the fither thands or performed to the entire observation. 8/12/15, at 12:51 p.m. NA-A are complete for R15, and not sanitized or washed her go cares to R15. NA-A stated,	F4	41				
	normal practice wou sanitizer after remov	guard." NA-A confirmed Ild be to wash or use hand ving gloves. NA-A reported cleaned the mechanical lifts						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	·	
		245403	B. WING _			8/14/2015
AND PLAN OF CORRECTION PASSIBLE STATES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BATTLE LAKE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 17 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 deaned 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	- BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIF 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515	•	•	
PRÉFIX	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	COMPLETION
F 441	daily, and indicate the mechanical lift time a resident us had used the lift h soiled tissue, ther sanitized with a binot nursing staff's between each resfacility mechanical sanitizing wipes in mechanical lifts. During interview of development coortissue would warrous between resident were expected to between resident development coorexpected to wash any kind of reside perform hand hygout of resident roof During interview of director of housek housekeeping stallifts daily, however also clean the lifts. The director of housek housekeeping stallifts daily, however also clean the lifts of the director of housek housekeeping stallifts daily, however also clean the lifts of the director of housek housekeeping stallifts daily, however also clean the lifts of the median to the medi	and nursing staff should wipe off its with bleach wipes after each es them. NA-A confirmed R15 andle while holding it with a instated it should have been each wipe. NA-A reported it is usual protocol to clean the lifts ident use, and did confirms I lifts were equipped with in bags attached to the on 8/13/15, at 4:30 p.m. staff idinator confirmed a soiled and a mechanical lift disinfecting use, and stated nursing staff idinator confirmed all staff were hands when visibly soiled after int care, and were expected to itene/ sanitize when going in and oms. On 8/14/15, at 1:09 p.m. the neeping stated the fif cleaned all of the mechanical r, nursing staff were expected to ite as needed after resident use. Usekeeping stated the lifts were infectant wipes in the tubs	F	441		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245403	B. WING _		0	8/14/2015	
	ROVIDER OR SUPPLIER MARITAN SOCIETY - BA	TTLE LAKE	•	STREET ADDRESS, CITY, STATE, ZIF 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (((EACH CORRECTIVE A: CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	were to wipe down al wipes between reside contaminated, and ve educated regarding the The facility's Hand Hy	ON confirmed nursing staff I mechanical lifts with bleach ent uses if the lift becomes erified all nursing staff were ne requirement. ygiene and Handwashing ected staff to perform hand	F4				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/11/2015 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 08/17/2015 245403 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 105 GLENHAVEN DRIVE **GOOD SAMARITAN SOCIETY - BATTLE LAKE** BATTLE LAKE, MN 56515 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 **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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

State Fire Marshal Division 445 Minnesota Street, Suite 145

St. Paul, MN 55101

TITLE

Electronically Signed

09/10/2015

(X6) DATE

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.

Facility ID: 00146

PRINTED: 09/11/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245403	B. WING	_		08/	17/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BATTLE LAKE		•	STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	Continued From pa	age 1	Κű	000				
	Or by e-mail to: Marian.Whitney@s	state.mn.us						
	or Angela.Kappenma	n@state.mn.us						
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:						
	A description of to correct the defication	what has been, or will be, done iency.						
	2. The actual, or pr	oposed, completion date.					a construction and a sign	
		r title of the person rection and monitoring to ence of the deficiency						
	The facility was sur	veyed as two buildings.						
	1-story building, with building was built in be Type II(000) cor	an Society Battle Lake is a thout a basement. The original of 1973 and was determined to distruction. In 1994 additions to					manufacturation for the second	
	north wing (Occupa OT/PT) were const were determined to In 2004 a small ves wing which include Type II (000) const link, to the new ass added to the south	est wing and to the north of the ational and Physical Therapy - cructed. The 1994 additions to be Type V(111) construction. Stibule was added to the west da walk in freezer, which is ruction. In 2007 a connecting sisted living apartments, was wing and was determined to 2010 an entrance addition	r					
	was constructed to which is 1-story, no	the north of the dining room basement and Type II (000) 11 a 16 bed addition was						

CENTE	RS FOR WEDICARI	E & MEDICAID SERVICES	T			0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245403	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	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 000	added to the east of determined to be T addition was added wing and was determined to be T addition was added wing and was determined to the smoke compartment barriers. The entire building system installed in Standard for the In (1999 edition). A first smoke detection a areas which was u with NFPA 72 "The (1999 edition), that department notificate detection is provided.	age 2 of the north wing and was Type II (111) and a 8 bed d to the east of the south east remined to be Type II (111) building is divided into 3 ents by 30 minute rated fire is sprinkler protected with a accordance with NFPA 13 estallation of Sprinkler Systems re alarm system with corridor nd smoke detection in common pdated in 2010 in accordance National Fire Alarm Code" is monitored for automatic fire action. Additional automatic fire ed in accordance with the ire Code (2007 edition).	K O				
K 046 SS=C	census of 53 residents inspection. The requirement at NOT MET as evidents NFPA 101 LIFE SA Emergency lighting provided in accordance of the STANDARD Based on observations staff, the facility has	apacity of 55 beds with a ents at the time of the tat 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD g of at least 1½ hour duration is ance with 7.9. 19.2.9.1. is not met as evidenced by: ations and an interview with s failed to ensure that thas been tested in	K 0-	Emergency battery powered lightistures were disconnected and by Otter Electric Company. The	removed	8/24/15	

	TO 1 OIT WILDIONITE	& MEDICAID SERVICES					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION G 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		B. WING		08	/17/2015		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE		105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		.,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
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		K 041	building is served by a 450 KW full-load emergency generator. Battery operated emergency lighting is not necessary and is disconnected perpetually.			
	emergency light: 1. During the revie battery backup emodocumentation and Maintenance Supe the facility failed to 30 second and ann battery backup emodocated by the emp	rvisor (CS) revealed the that conduct the required Monthly hual 90 minute testing of the					
K 047 SS=C	Maintenance Supe NFPA 101 LIFE SA Exit and directional accordance with se	FETY CODE STANDARD signs are displayed in action 7.10 with continuous rived by the emergency lighting	K 04	7		9/18/15	

PRINTED: 09/11/2015 FORM APPROVED OMB NO. 0938-0391

	RS FOR MEDICARE	& MEDICAID SERVICES				no mo.	0930-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245403	B. WING	,,		08/1	7/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE			05 GLENHAVEN DRIVE ATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 047	This STANDARD is Based on observational exit significant practice of the prevented a means in a timely manner. On facility tour betwoelds.	ige 4 s not met as evidenced by: tion and staff interview, the provide 2 of several ins that marks the means of ordance with NFPA Life Safety lition), Sec. 7.10.5.2. The ould affect residents, staff and of properly illuminated exit sign is of egress from being utilized in an emergency situation. In the second of the secon	KO	147	Burned out light bulbs in the exit ligat the staff break room have been replaced by the maintenance depart on 8/24/15. A process for checking all exit lighting been put into the facility Preventive Maintenance system, and will be monitored by the facility Quality Assign Process with routine audits monthly months and with quarterly audits for additional year. A sign labeled as, "NO EXIT" is ord and will be installed on the Heritage Room door that leads to the outside building.	ng has surance for 6 r an ered e Day	
K 056 SS=C	the employee breal illuminated. 2. The Heritage Date to the outside of the exit that is not label. This deficient pract Maintenance Super NFPA 101 LIFE SAME of the Installation of provide complete cobuilding. The system	ices was confirmed by the	ΚC	056			9/30/15

Event ID: MQKK21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245403	B. WING			08/	17/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP COI 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 056	Water-Based Fire I supervised. There supply for the systesystems are equipped.	, and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler ped with water flow and tamper e electrically connected to the	Kα	956			
	Based on observation found that the autorinstalled and mainta NFPA 13 the Stand Sprinkler Systems (the sprinkler system (99) could allow systems and the sprinkler system (sprinkler system).	s not met as evidenced by: tions and staff interview, it was matic sprinkler system is not ained in accordance with ard for the Installation of (99). The failure to maintain in in compliance with NFPA 13 stem being place out of service in the fire protection system ent of an emergency that sidents, visitors and staff of the		The second secon	Replacement sprinkler heads will installed by Nova Fire Protection, I 9/30/15. Facility sprinkler heads will be mor by Nova Fire Protection, Inc. as patheir annual fire inspection survey. Maintenance Director will schedule test on an annual basis.	nc. by iitored rt of Facility	
	08/17/2015,, observ	veen 9:00 AM to 1:30 PM on vations have revealed that d sprinkler heads located in					
K 062 SS=F	Maintenance Super NFPA 101 LIFE SA Required automatic	ices was confirmed by the rvisor (CS). FETY CODE STANDARD sprinkler systems are ained in reliable operating	ΚC	62			8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED
		245403	B. WING		08/	17/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BATTLE LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BË	(X5) COMPLETION DATE
K 062		age 6 nspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,	K 062			
	Based on docume with staff, the facilit and maintain the all accordance with NI Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire I deficient practice disprinkler system is fully operational in	s not met as evidenced by: ntation review and interview by has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), d 4.6.12, NFPA 13 Installation as (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could sidents, staff and visitors.		A facility fire sprinkler test was p on 8-20-15 by Nova Fire Protecti Systems, Inc. An annual inspecti scheduled by the facility Mainten Director. On-going compliance w standard will be monitored by the Maintenance Director as part of the physical plant preventive mainter program.	on on will be ance ith this a facility the	
	08/17/2015, a revie interview with the I revealed that at the facility failed to pro	veen 9:00 AM to 1:30 PM on ew of documentation and Maintenance Supervisor (CS) e time of the inspection the vide any documentation for a sprinkler test having been				
K 067 SS=F	Maintenance Supe NFPA 101 LIFE SA Heating, ventilating with the provisions	rices was confirmed by the rvisor (CS). IFETY CODE STANDARD I, and air conditioning comply of section 9.2 and are installed the manufacturer's	K 06	7		9/24/15

	CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			IND NO.	0330-0331
· washington	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
f			245403	B. WING		08/	17/2015
	NAME OF	PROVIDER OR SUPPLIER		i i	STREET ADDRESS, CITY, STATE, ZIP CODE		
	GOODS	AMARITAN SOCIETY	' - BATTLE LAKE	II	BATTLE LAKE, MN 56515		
	(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)		(X5) COMPLETION DATE
	K 067		age 7 9.5.2.1, 9.2, NFPA 90A,	K 067			
		Based on docume interview, the fire/s been maintained ir requirements of NI deficient practice doperation of the fire allow smoke migra	is not met as evidenced by: entation review and staff emoke damper system has not a accordance with the FPA 90(99) section 3-4.7. This loes not ensure the proper e/smoke dampers and could tion to negatively affect the ints, staff and visitors in the		A service contract has been estat with Protection Service Systems to conduct a facility "smoke damper" and provide documentation of the inspection/test. Compliance with the standard will be maintained by the Maintenance Director through the preventive maintenance program done once every 4 years.	test his facility	
		08/17/2015, it was the facility's fire an test/inspection doc by interview with th (CS), that the facili documentation ver	ween 9:00 AM to 1:30 PM on revealed during the review of d smoke damper umentation and was confirmed to Maintenance Supervisor ty had failed to provide ifying that the fire and smoke in tested/inspected within the				
	K 073 SS=D	Maintenance Supe NFPA 101 LIFE SA	AFETY CODE STANDARD lecorations of highly flammable	K 073			8/20/15

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG 01 - MAIN BUILDING 01	COMPLETED	
		245403	B. WING			17/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP CO 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 073	Continued From pa	age 8	К0	73		
	Based on observal facility failed to main accordance with (00) section 19.7.5 maintain the combithe facility in according Code 101 (00) courapidly migrate throngatively affect the	is not met as evidenced by: tions and staff interview, the intain combustible decoration NFPA Life Safety Code 101 .4. The failure to treat and ustible decorations throughout dance with NFPA Life Safety Id allow smoke and fire to ough the corridors and e egress capability in the event or residents, visitors and staff		The facility has removed all non-complying decorations of corridors and established a prestrict the use of combustible decorations in theses areas Enforcement will be monitor facility Quality Assurance Coroutine audits performed monitors of months and quarterly additional year. The Quality Director will be responsible to compliance.	from public policy to policy to ple in the future. ed by the pumittee with porthly for the for an Assurance	
K 144 SS=D	On facility tour betwo 8/17/2015, observed on resident rooms are fire retardant of any type of approved This deficient practing Maintenance Super NFPA 101 LIFE SAGE Generators are installed to the same type of	FETY CODE STANDARD pected weekly and exercised ninutes per month in	K 1	44		9/17/15

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 0 1	COMPLETED	
		245403	B. WING		08/	17/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 144	Continued From pa	ge 9	K 14	44		
	Based on documer interview, the facility generators in accord 2000 NFPA 101 - 6-4.2 (a) & (b) and could affect all patients. Findings include: On facility tour betw 08/17/2015, documergency generat interview with the M was reveled that the complete weekly and reports for their gen. The facility had docemergency generat time; but the facility documentation at the all the weekly and maintenance check these maintenance.	s were completed during the intervals. tion was verified by the		Facility will acquire the acceptab documentation form from the State Marshall Division and maintain representing of all mandated operations of the emergency gene. The facility Director of Maintenan responsible to carry out this active.	te Fire gular onal rator. ce will be	

Event ID: MQKK21

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 02 - 2007 CONNECTING LINK 245403 08/17/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 105 GLENHAVEN DRIVE **GOOD SAMARITAN SOCIETY - BATTLE LAKE BATTLE LAKE, MN 56515** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 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 TITLE (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

Facility ID: 00146

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION 3 02 - 2007 CONNECTING LINK	(X3) DATE SURVEY COMPLETED		
		245403	B. WING	÷		08/	17/2015	
,	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BATTLE LAKE	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
K 000	Continued From pa Or by e-mail to: Marian.Whitney@s or Angela.kappenmar	tate.mn.us	K	000				
	DEFICIENCY MUS FOLLOWING INFO 1. A description of value to correct the deficition of value and	what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency veyed as two buildings.						
	1-story building, with building was built in be Type II (000) conthe south of the we north wing (Occupa OT/PT) were constituted wing which included Type II (000) construink, to the new assadded to the south be Type V (111). In was constructed to which is 1-story, no	an Society Battle Lake is a hout a basement. The original 1973 and was determined to struction. In 1994 additions to st wing and to the north of the ational and Physical Therapy ructed. The 1994 additions be Type V(111) construction tibule was added to the west da walk in freezer, which is ruction. In 2007 a connecting isted living apartments, was wing and was determined to 2010 an entrance addition the north of the dining room basement and Type II (000)						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2007 CONNECTING LINK			(X3) DATE SURVEY COMPLETED	
		245403	B. WING		08	/17/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP COD 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	added to the east of determined to be T addition was added wing and was dete construction. The smoke compartme barriers. The entire building system installed in Standard for the In: (1999 edition). A fir smoke detection at areas which was up with NFPA 72 "The (1999 edition), that department notificate detection is provide Minnesota State Fi	of the north wing and was type II (111) and a 8 bed of to the east of the south east remined to be Type II (111) building is divided into 3 nts by 30 minute rated fire is sprinkler protected with a accordance with NFPA 13 stallation of Sprinkler Systems alarm system with corridor and smoke detection in common potated in 2010 in accordance National Fire Alarm Code" is monitored for automatic fire ation. Additional automatic fire ad in accordance with the re Code (2007 edition).	ΚO				
K 056 SS=C	NOT MET as evide NFPA 101 LIFE SA There is an automa in accordance with Installation of Sprin components, device complete coverage The system is main NFPA 25, Standard	242 CFR, Subpart 483.70(a) is inced by: FETY CODE STANDARD atic sprinkler system, installed NFPA 13, Standard for the kler Systems, with approved es, and equipment, to provide of all portions of the facility. Intained in accordance with for the Inspection, Testing, f Water-Based Fire Protection	К 0	56		8/20/15	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG 02 - 2007 CONNECTING LINK	(X3) DATE SURVEY COMPLETED	
		245403	B. WING		08/	17/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 056	supply for the syste	em. The system is equipped tamper switches which are	K 0	56		
	Based on observary found that the auto installed and maint NFPA 13 the Stand Sprinkler Systems the sprinkler system (99) could allow systems and allow systems and allow systems are decreased capability in the every sound that the systems is the systems of the s	s not met as evidenced by: tions and staff interview, it was matic sprinkler system is not ained in accordance with lard for the Installation of (99). The failure to maintain in in compliance with NFPA 13 stem being place out of service in the fire protection system ent of an emergency that sidents, visitors and staff of the		Complying sprinkler heads were in the 16-plex mezzanine mecha room on 8/20/2015 by Nova Fire Protection Systems, Inc. The fac Director of Maintenance will mon compliance with the noted stands annual basis.	nical ility itor	
	08/17/2015,, observed there are two standards mixed in with	veen 9:00 AM to 1:30 PM on vations have revealed that lard response type of sprinkler n quick response type sprinkler ed in the 16 plex mezzanine				
K 062 SS=F	Maintenance Super NFPA 101 LIFE SA Required automatic	ices was confirmed by the rvisor (CS). FETY CODE STANDARD c sprinkler systems are ained in reliable operating	K 00	52		8/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2007 CONNECTING LINK			COMPLETED	
		245403	B. WING			08/	17/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BATTLE LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		05 GLENHAVEN DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	condition and are ir	age 4 nspected and tested 6, 4.6.12, NFPA 13, NFPA 25,	Κ0	62			
	Based on docume with staff, the facilit and maintain the au accordance with NF Section 18.7.6, and of Sprinkler System for the Inspection, Water Based Fire F deficient practice do sprinkler system is fully operational in the	ntation review and interview y has failed to properly inspect atomatic sprinkler system in FPA 101 Life Safety Code (00), 14.6.12, NFPA 13 Installation as (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This pees not ensure that the fire functioning properly and is the event of a fire and could sidents, staff and visitors.			Note detailed POC response for the under section titled "01- Main Build		
	08/17/2015, a revie interview with the M revealed that at the facility failed to prov	veen 9:00 AM to 1:30 PM on w of documentation and Maintenance Supervisor (CS) time of the inspection the vide any documentation for a sprinkler test having been					
K 067 SS=F	Maintenance Super NFPA 101 LIFE SA Heating, ventilating	FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed	Κ0	67			9/24/15

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1 '	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2007 CONNECTING LINK			(X3) DATE SURVEY COMPLETED	
		245403	B. WING		08/	17/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BATTLE LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 067	,	ge 5 2, 18.5.2.1, 18.5.2.2, NFPA	K 067	7			
	Based on documer interview, the fire/sr been maintained in requirements of NF deficient practice doperation of the fire allow smoke migrat	s not met as evidenced by: ntation review and staff moke damper system has not accordance with the PA 90(99) section 3-4.7. This bes not ensure the proper sysmoke dampers and could ion to negatively affect the ts, staff and visitors in the		Note detailed POC response for the under section titled "01- Main Build			
	08/17/2015, it was rethe facility's fire and test/inspection docuby interview with the (CS), that the facility documentation verified.	veen 9:00 AM to 1:30 PM on revealed during the review of a smoke damper sumentation and was confirmed a Maintenance Supervisor y had failed to provide fying that the fire and smoke in tested/inspected within the					
K 073 SS=D	Maintenance Super NFPA 101 LIFE SA	FETY CODE STANDARD ecorations of highly flammable	K 073	3		8/20/15	

Event ID: MQKK21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		245403	B. WING			U81	17/2015	
	PROVIDER OR SUPPLIER		D. WIIICO	S 10	TREET ADDRESS, CITY, STATE, ZIP CODE D5 GLENHAVEN DRIVE ATTLE LAKE, MN 56515	1 001	1772013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 073	Based on observa facility failed to mai in accordance with (00) section 18.7.5 maintain the combit the facility in accord Code 101 (00) coul rapidly migrate thro negatively affect the	age 6 s not met as evidenced by: tions and staff interview, the ntain combustible decoration NFPA Life Safety Code 101 .4. The failure to treat and ustible decorations throughout dance with NFPA Life Safety Id allow smoke and fire to ough the corridors and e egress capability in the event or residents, visitors and staff	K)73	Note detailed POC response for the under section titled "01- Main Build	nis tag ing"		
K 144 SS=D	08/17/2015, observed could not verify if the could not verify any type of approved this deficient pract Maintenance Supe NFPA 101 LIFE SA Generators are inspection.	FETY CODE STANDARD pected weekly and exercised ninutes per month in	K	144			9/17/15	
	This STANDARD i	s not met as evidenced by:						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 02 - 2007 CONNECTING LINK			COMPLETED		
		245403	B. WING			08/	17/2015
	VIDER OR SUPPLIER ARITAN SOCIETY	- BATTLE LAKE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 05 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
Bi int ge of 6-4 co	terview, the facility enerators in accor- 2000 NFPA 101 - 4.2 (a) & (b) and 6 ould affect all patie	ge 7 Intation review and staff Interior review and staff Intation review and staff Intain review and staff Intation review and staff Intain review a	K 1	144	Note detailed POC response for the under section titled "01- Main Build		
Or 08 em int wa co rep Th em tim do all ma the	8/17/2015, documents of the complete with the Mass reveled that the amplete weekly an ports for their generatine; but the facility had documentation at the the weekly and maintenance checkings.	s were completed during the intervals.					



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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.

Good Samaritan Society - Battle Lake August 28, 2015 Page 2

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 Weath

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		00146	B. WING		08/14/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	
GOOD SA	MARITAN SOCIETY - BA	TTLE LAKE	NHAVEN DRIVE LAKE, MN 5651:	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 000	O00 Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of whe corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessment of the runumber and MN Rule.	ther a violation has been			
	that may result from rorders provided that at the Department within notice of assessment INITIAL COMMENTS You have agreed to preceipt of State licens the Minnesota Depart Informational Bulletin	: articipate in the electronic ure orders consistent with ment of Health 14-01, available at e.mn.us/divs/fpc/profinfo/inf			
	delineated on the atta	-			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/04/15 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 20 MQKK11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00146	B. WING		08/12	1/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 00/1-	#/2013
		105 GLENI	HAVEN DRIVE	,		
GOOD SA	MARITAN SOCIETY - BA	BATTLE LA	AKE, MN 5651	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	you electronically. Al is necessary for State enter the word "correctext. You must then in State licensure proce completion date, the corrected prior to elect Minnesota Department On August 10th, 11th, 2015 surveyors of this the above provider arorders are issued. Plelectronic plan of correviewed these orders they will be completed Minnesota Department the State Licensing Confederal software. Tag assigned to Minnesota Nursing Homes. The assigned tag nuncolumn entitled "ID Fistatute/rule out of constant "Summary Statement and replaces the "To correction order. This findings which are in after the statement, "evidence by." Following the Suggested Medical Time period for Correction Corr	orders being submitted to though no plan of correction a Statutes/Rules, please cted" in the box available for idicate in the electronic iss, under the heading date your orders will be ctronically submitting to the int of Health. 12th, 13th and August 14th, is Department's staff, visited ind the following correction ease indicate in your rection that you have is, and identify the date when id. Int of Health is documenting orrection Orders using numbers have been a state statutes/rules for in the far left prefix Tag." The state inpliance is listed in the column also includes the violation of the state statute. This Rule is not met as ing the surveyors findings ethod of Correction and ction. Dither The Headling of the column and ction.	2 000			
		VHICH STATES, OF CORRECTION." THIS AL DEFICIENCIES ONLY.				

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 2 of 20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		00146	B. WING		08/14/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREE	TADDRESS, CITY, STA	ATE, ZIP CODE	001111111111111111111111111111111111111
GOOD SA	MARITAN SOCIETY - BA	TTLE LAKE	ENHAVEN DRIVE E LAKE, MN 565		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Continued From page	2	2 000		
	THIS WILL APPEAR	ON EACH PAGE.			
		IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.			
21385	MN Rule 4658.0800 S Staff assistance	Subp. 3 Infection Control;	21385		9/25/15
	Personnel must be as infection control progr	ance with infection control. ssigned to assist with the ram, based on the needs of sing home, to implement edures of the infection			
	by: Based on observation review, the facility fail handwashing techniquersonal cares for 1 cobserved. In addition	ues were followed during of 3 residents (R15) , the facility failed to ensure properly sanitized after use		Corrected	
	7/21/15, identified R1 included diabetes, de MDS identified R15 m daily decision making and long term memor	num Data Set (MDS) dated 5 had diagnoses which mentia and anxiety. The noderately impaired skills for and had both short term y problems. Further, the ed extensive assistance of activities.			

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 3 of 20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		00146	B. WING		08/14/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOOD SA	AMARITAN SOCIETY - BA	TTLE LAKE	HAVEN DRIVE AKE, MN 5651	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
21385	During continuous ob 12:40 p.m. to 12:54 p (NA)-A was observed transfer from the where transfer from the where at 12:40 p.m., NA-A on both hands and utilift to transfer R15 from toilet. -at 12:42 p.m. NA-A removed R15's income R15 onto the toilet and gloves from both hands toilet, R15 started coutissue and handed to mouth. R15 wiped his times with the tissue, in his left hand while hift handle. -at 12:44 p.m. NA-A at the mechanical lift to a position and proceeds area with a wet wipe, barrier cream and renstated he needed to unimediately reached the lift in one hand, and the mechanical lift armonto the toilet. -at 12:46 p.m. NA-A at proceeded to cleanse wet wipes, brown bow wipe. NA-A removed immediately reach output to the toilet.	servation on 8/12/15, from .m., nursing assistant while R15 was assisted to elchair to the toilet. applied disposable gloves dized a mechanical standing m the wheelchair to the coosened R15's pants, tinent product and lowered d proceeded to remove the ds. While seated on the ughing, and NA-A retrieved a R15 to wipe his nose and s mouth and nose multiple then held the soiled tissue holding onto the mechanical applied fresh gloves, utilized assist R15 to a standing ed to cleanse R15's perineal removed one glove applied hoved the other glove. R15 hase the toilet again, NA-A out and held the controls for and placed the other hand on and lowered R15 back applied fresh gloves, and R15's perineal area with livel observed on cleansing her gloves from both hands, to adjust R15's incontinent mediately transferred R15	21385		

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 4 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00146	B. WING		08/14/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOOD SA	MARITAN SOCIETY - BA	TTLE LAKE	IAVEN DRIVE AKE, MN 5651	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
21385	21385 Continued From page 4		21385		
	hands on the mechan mechanical lift out of a alcove in the facility NA-A had not washed	her hands or performed			
	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.				
	development coordinatissue would warrant to between resident use were expected to disingular between resident used development coordinate expected to wash har any kind of resident coordination.	ator confirmed all staff were nds when visibly soiled after are, and were expected to e/ sanitize when going in and			

Minnesota Department of Health STATE FORM

Minnesota Department of Health					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00146	B. WING		08/14/2015
		00140			1 00/14/2010
NAME OF PR	ROVIDER OR SUPPLIER	STR	REET ADDRESS, CITY, STA	ATE, ZIP CODE	
GOOD SA	MARITAN SOCIETY - BA	TTIFIAKE 105	GLENHAVEN DRIVE		
OOOD OA	BATTLE			5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21385	Continued From page	e 5	21385		
21385	director of housekeep housekeeping staff cle lifts daily, however, not also clean the lifts as The director of house equipped with disinfer attached to the mechanomic director of nursing (DC expected to wash and removing gloves and surface. The DON restaff to keep hand sar that purpose. The DC were to wipe down all wipes between reside contaminated, and veeducated regarding the The facility's Hand Hy Policy dated 6/14, director hygiene after removing SUGGESTED METHODON or infection continued educate staff or program along with ratio ensure proper tech	/14/15, at 1:09 p.m. the bing stated the eaned all of the mechanical cursing staff were expected to needed after resident use. keeping stated the lifts were ctant wipes in the tubs anical lifts. /14/15, at 1:18 p.m. the DN) stated all staff were d/or sanitize hands after before touching another ported the facility directed intizer in their pockets for DN confirmed nursing staff I mechanical lifts with bleacent uses if the lift becomes erified all nursing staff were ne requirement. // giene and Handwashing ected staff to perform handing gloves.	h h		
	with the quality assura TIME PERIOD FOR ((21) days.	ance program. CORRECTION: Twenty-one	3		

STATE FORM 6899 If continuation sheet 6 of 20 MQKK11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00146	B. WING		08/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	ATE, ZIP CODE	
GOOD SA	MARITAN SOCIETY - BA	ATTLE LAKE	LENHAVEN DRIVE LE LAKE, MN 565 [,]		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21426	Continued From pag	e 6	21426		
21426	Prevention And Conf (a) A nursing home maintain a comprehe infection control programment tuberculosis issued by the United Control and Preventi Tuberculosis Elimina Morbidity and Mortal This program must in infection control plan unpaid employees, or residents, and volunt Health shall provide regarding implement	provider must establish and ensive tuberculosis gram according to the most infection control guidelines States Centers for Disease on (CDC), Division of tion, as published in CDC's ity Weekly Report (MMWR). Include a tuberculosis that covers all paid and contractors, students, teers. The Department of technical assistance ation of the guidelines.	21426		9/25/15
	by: Based on interview a failed to ensure that received timely base symptom screening a tuberculin skin test(T reviewed. Findings include: Employee (E)- A, ha 2/13/15. A tuberculin been completed on S	and record review, the facility all health care workers line tuberculosis(TB) and timely two-step (ST)for 2 out of 5 employees d been hired by the facility on a symptom screening had 0/11/14, a total of 5 months ire. E-A had received the first		Corrected	

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 7 of 20

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
	00146	B. WING		08/14/2015
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	FE ZIR CODE	
TWINE OF THOUSEN ON OUT ELEM		ENHAVEN DRIVE	, 2 3332	
GOOD SAMARITAN SOCIETY	- BATTLE LAKE	E LAKE, MN 5651	5	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21426 Continued From p	Continued From page 7			
a total of 4 month E -B had been hir received the 1st so 2nd step TST on and 2 days prior to lacked documents screening completed on 8/13/14, at a passistant director accepted the tube (TST) information employers and haverified E -A and mantoux (TST) are peated when his On 8/14/15 at 9:5 (DON) stated employees start in had it done previous Review of the pole Plan For Healthca indicated new employees to the pole Plan For Healthca indicated new employees the contraindicated. I verified TST result per state regulation Review of the pole Testing revised on will have baseline method. This invotes the completed in the complete in th	s and 13 days prior to hire. ed by the facility on 4/2/15, had tep TST on 12/22/14 and the 12/31/14, a total of 4 months o hire. The personnel record ation of a TB symptom ted for E-B. oproximately 8:30 a.m., the of nursing (ADON) stated she orculin screening and Mantoux from the employee's previous d felt that was adequate. ADON E- B should have had the 2 step and tuberculosis screening red by the facility. 5 a.m. the director of nursing oloyees should have Mantoux intouxs (TST) given before in the facility, regardless if they really. cy titled, Tuberculin Control are Workers, dated 6/2012, ployees will have baseline TB eted utilizing the tuberculin skin p method, unless in addition, new employees with its not more than 30 days old (or ion) will not be retested. cy titled, Tuberculin Skin in 8/14, indicated the employee screening using the TST 2 step lived administrating the initial ite read in 48 to 72 hours by it or physician and the 2nd step			

Minnesota Department of Health

nursing /designee could develop a process to ensure that health care workers receive a

STATE FORM 6899 MQKK11 If continuation sheet 8 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COM		
		00146	B. WING		08/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
GOOD SA	MARITAN SOCIETY - BA	TTLE LAKE	NHAVEN DRIVE LAKE, MN 5651		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
21426	Continued From page	e 8	21426		
	baseline screening fo two-step mantoux.	r symptoms of TB and a			
	TIME PERIOD FOR (FOURTEEN (14) DAY				
21990	MN St. Statute 626.58 Maltreatment of Vulne		21990		9/25/15
	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.				
	by: Based on interview at facility failed to immed agency (SA) and faile investigation for 2 of 2	t is not met as evidenced and document review, the diately report to the State d to complete a thorough residents (R15, R3) for rigin and potential neglect of use prohibition.		Corrected	
	Findings include:				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		CONFLETED	
		00146	B. WING		08/1	4/2015	
NAME OF D	ROVIDER OR SUPPLIER	QTDEET ADI	DRESS, CITY, STA	TE ZIP CODE			
INAIVIE OF PI	NO VIDEN ON SUFFLIER		HAVEN DRIVE	, 211 JODE			
GOOD SA	MARITAN SOCIETY - BA	TTLE LAKE	AKE, MN 5651	E			
	OLUMBA DV OT						
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE	
				DEFICIENCY)			
21990	Continued From page	9	21990				
	D15's injury of unknow	wn origin was not reported					
	to the SA and thoroug	-					
	to the SA and thoroug	iny investigated.					
	R15's quarterly MDS	dated 7/21/15, identified					
		hich included dementia,					
		epression, and anxiety. The					
	MDS identified R15 h	ad moderately impaired					
		ly decision making and both					
		erm memory problems.					
	Further, the MDS ider	•					
		of one staff for bed mobility,					
		oileting, personal hygiene					
	and bathing.						
	Review of R15's care	nlan dated 3/31/15					
		paired cognition function					
	-	um and confusion. The care					
	plan indicated R15 wo						
		as difficult to re-direct, had					
	poor judgement with o						
	needing assistance w	rith decisions and					
	verbalizations.						
		ent report dated, 4/12/15,					
		ard an alarm and found R15					
		hroom doorway. The report					
		vith his head next to the nd R15 reported he was					
		n. The report—identified R15					
	• •	/, impaired vision, and					
		the report identified no					
		I of the incident and listed					
		tears and was bleeding					
		and left inner forearm and					
	did not report pain.						
		ress notes dated 4/12/15					
	revealed the following	j:					

Minnesota Department of Health STATE FORM

STATE FORM 6899 MQKK11 If continuation sheet 10 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED		
		00146		B. WING		08	3/14/2015
NAME OF P	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY - BA	TTLE LAKE		IAVEN DRIVE AKE, MN 5651	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21990	-4:30 a.m., nursing as the floor in front of the had bleeding at the te tears. R15 had been bed by facility staff ar -6:10 a.m., when assiculd not bear full we leg was slightly turned of dizziness, pain and note indicated R15 had hospital for evaluation 10:00 a.m. the facility R15's hip fracture and repair of the hip fracture and repair of the hip fracture. During interview on 0 trained medication aid had very poor memory concentrating or recard During interview on 8 registered nurse (RN) dementia, poor memory redirection. RN-A staffer the 4/12/15 fall, evaluation and had be hip which required succonfirmed R15's fall we staff, confirmed the fafell. RN-A stated she an injury of unknown dementia with poor mount with significant injury. During interview on 0 DON confirmed R15 and was four	esistant found R15 lying of bathroom doorway. R15 emple, and multiple skin assisted from the floor in a da mechanical lift devices sted to ambulate, R15 ight on the right leg and a doutward. R15 complair I had a small emesis. The deben transferred to the non 4/12/15 at 7:45 a.m. was contacted to confirm would require surgical are. 8/13/15 at 11:24 a.m., de (TMA)-A-reported R15 y and had a difficult time lling past events. 7/13/15 at 4:59 p.m., and had a difficult time ling past events. 7/13/15 at 4:59 p.m., and had a difficult time len diagnosed with fracting recall and required at the R15 developed pain was sent to the hospital the en diagnosed with fracting cal repair. RN-A was not witnessed by any acility had assumed R15 has never viewed this a origin, even though R15 itemory, and was diagnosed.	to e. right ned e e, at m for ured / as has	21990			

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 11 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	20146		B. WING			/4.4/0045	
		00146			08	/14/2015	
NAME OF P	ROVIDER OR SUPPLIER		address, city, stat Enhaven drive	TE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - BA	ATTLE LAKE	ELAKE, MN 5651	5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21990	Continued From page	e 11	21990				
	the facility had not pro consideration the rep unexplainable injuries cognitively impaired r	orting requirement regarding s of unknown source with					
	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.						
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	

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 12 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00146	B. WING		08/1	4/2015
	ROVIDER OR SUPPLIER	105 GLENI	RESS, CITY, STA	TE, ZIP CODE		
GOOD SA	.MARITAN SOCIETY - BA	TTLE LAKE	KE, MN 5651	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
22000	comply with any rules promulgated by the lice (b) Each facility, incomply agency and personal providers, shall developrevention plan for earesiding there or rece. The plan shall contain assessment of: (1) the abuse by other individed vulnerable adults; (2) other vulnerable adults specific measures to risk of abuse to that products. For the purpoterm "abuse" includes (c) If the facility, extend personal care attained by the facility of the results of a complete the risk that the reasonably be expect facility and persons of unsupervised. Under of a vulnerable adult's misconduct or physic such information from authority or through a serious providers.	f abuse. The plan shall governing the plan censing agency. cluding a home health care care attendant services op an individual abuse ach vulnerable adult iving services from them. In an individualized the person's susceptibility to duals, including other the person's risk of abusing tis; and (3) statements of the the taken to minimize the the erson and other vulnerable the ses of this paragraph, the the self-abuse. The physical aggression dividual abuse prevention the adult has committed a the of physical aggression dividual abuse prevention the surres to be taken to the vulnerable adult might the do pose to visitors to the furtiside the facility, if this section, a facility knows the shistory of criminal that aggression if it receives that a law enforcement medical record prepared by the realth care provider, or	22000			

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00146		B. WING		08/14/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 00/1	4/2013
	MARITAN SOCIETY - BA	105 GLEN	HAVEN DRIVE	,		
	IWARITAN SOCIETT - BA	BATTLE L	AKE, MN 5651	5	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
22000	Continued From page	e 13	22000			
	by: Based on interview at facility failed to implet neglect policy and proimmediatel notificatio and conduct a thorouresidents (R15, R3) is	ocedures related to n to the state agency (SA) gh investigation for 2 of 2 reviewed for abuse icant injuries of unknown		Corrected		
	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.					
	titled MN Nursing Hot Determine Potential F Follow Up Process fo Altercation dated 6/13 an incident was repor the form identified the conjunction with appli regulations and is not professional judgeme	Reportability and Facility r Resident to Resident B, identified situations when table to the SA. In addition, e tool should be used in icable federal nursing home intended to replace				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ARED: '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00146	B. WING _		08/14/2015
	ROVIDER OR SUPPLIER MARITAN SOCIETY - E	BATTLE LAKE	STREET ADDRESS, CITY, 105 GLENHAVEN DRI BATTLE LAKE, MN 5	VE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY R LSC IDENTIFYING INFORMA	FULL PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETE D THE APPROPRIATE DATE
22000	Injures of Unknown dated 5/13 identified was reportable to the identified the tool was to be used in conjur Nursing Home regu	ge 14 Term Care Reportablity Source under F225 for d situations when an in- le SA. In addition, the fi- las optional, if used, this nction with applicable F lations. Causes of injurable as mistreatment, a	m, cident orm s tool is ederal ies		
	to the SA and thoro R15's quarterly MD: R15 had diagnoses delusional disorder, MDS identified R15 cognitive skills for d short-term and long Further, the MDS id extensive assistance transfers, dressing, and bathing. Review of R15's cal	sown origin was not repughly investigated. S dated 7/21/15, identify which included demendepression, and anxiey had moderately impairally decision making arterm memory problem entified R15 required e of one staff for bed motolleting, personal hygotre plan dated 3/31/15, mpaired cognition functives.	ied tia, ty. The ed nd both s. nobility, iene		
	relation to CVA, deliplan indicated R15 completed by staff, poor judgement with needing assistance verbalizations. Review of R15's increvealed staff had hon the floor in the bidescribed R15 lying bathroom doorway,	irium and confusion. T would forget cares just was difficult to re-direct n decisions resulting in	t, had 2/15, and R15 report he		

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 15 of 20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		MRED:	PLE CONSTRUCTION B:		(X3) DATE SURVEY COMPLETED	
		00146	B. WING	 	08/14/20)15
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, S	STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY - E	BATTLE LAKE	105 GLENHAVEN DRIN BATTLE LAKE, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY R LSC IDENTIFYING INFORM,	FULL PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE CO O THE APPROPRIATE	(X5) OMPLETE DATE
22000	had impaired memory drowsiness. Further witnesses were four R15 had multiple sk from the right templ did not report pain. Review of R15's prorevealed the following the floor in front of the had bleeding at the tears. R15 had been bed by facility staff and the staff of the had bleeding at the tears. R15 had been bed by facility staff and the staff of the highest pain and the indicated R15 hospital for evaluati 10:00 a.m. the facility R15's hip fracture a repair of the hip fracture and th	ory, impaired vision, and the report identified rend of the incident and lain tears and was bleed and left inner forearm ogress notes dated 4/1 ng: assistant found R15 ly the bathroom doorway. Itemple, and multiple send assisted from the floor and a mechanical lift desisted to ambulate, Reveight on the right legated outward. R15 commond had a small emesis that been transferred to on on 4/12/15 at 7:45 at y was contacted to cond would require surgicular. 08/13/15 at 11:24 a.m. aide (TMA)-A-reported ory and had a difficult of the right legated.	isted diing n and 2/15 ing on R15 kin or into evice. 15 and right plained . The o the a.m., at nfirm cal ., R15 time d oain ital for ractured any			

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 16 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00146	B. WING		08	3/14/2015
	ROVIDER OR SUPPLIER	ATTLE LAKE	REET ADDRESS, CITY, STATI IS GLENHAVEN DRIVE ATTLE LAKE, MN 56515			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
22000	an injury of unknown dementia with poor with significant injury. During interview on DON confirmed R15 4/12/15 and was for bathroom doorway.	e has never viewed this as a origin, even though R15 has memory, and was diagnose y. 08/13/15 at 11:28 a.m., the is had an unwitnessed fall on und on floor with walker in The DON reported R15's	d			
	reliable source for in the facility had not p consideration the re unexplainable injurie cognitively impaired confirmed R15's inci investigation.	porting requirement regarding so of unknown source with residents. The DON ident lacked a thorough				
	, , ,	wn origin and potential not reported to the SA and ted.				
	identified R3 had dia arthritis, osteoporos MDS identified R3 h	uired extensive assistance	ne			
	revealed R3 was for floor in her room. R3 held her chest area her. The report identhe face and a bruishand. The report identities witnesses found and	lent report, dated 4/26/15, und lying on her back on the had hollered out in pain ar when staff attempted to mortified R3 had an abrasion to e on the back of the right entified there were no did R3 did not remember fallingsode due to confusion,	nd ve			

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 17 of 20

Minnesota Department of Health

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN			A. BUILDING: _		O O IVII E	LILD		
		00146		B. WING		08/1	4/2015	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - BA	ATTLE LAKE		HAVEN DRIVE				
				AKE, MN 5651				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
22000	Continued From page	e 17		22000				
	impaired memory and	d gait imbalance						
	Review of R3's progr 4/28/15 revealed the		1/26/15 to					
	-On 4/26/15, at 2:57 her back on the floor a abrasion on foreher slight swelling in area her way to the bathronot remember falling, when attempted to mothest area hurt. R3's to be more elevated to pack was applied to constant at was observed to look the tarea when staff R3 had rapid respirat at that time, and admission was attempted. Call prophine order for rebeen unable to assission.	of her room. No ad with no draina. R3 stated she som, and indicate. R3 hollered outlove and indicate left side of chest hen right side at chest area & forces note identified holler out in pain attempted to proceed again to I esidents comfort,	ted to have age, with had been on ed she did it in pain ed her mid it was noted and an ice ehead. at 11:15a.m. and hold rovide cares. ygen levels ygen (O2) Dr. for staff has					
	requested prn O2 ord -On 4/28/15, at 2:02 a fall with injury on 4/ alarm pad while in be with transfers and am pain to chest. Staff or MD related to morphi to sternum. Family ag within the confines of resident comfort and	der if resident ne p.m. DON identi '26/15. Now has ed as resident re abulation due to continue to work of the use and susp greed resident si	eded. fied R3 had sensor quires assist increased closely with bected injury hould stay					
	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							

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 18 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN			A. BUILDING:			LLTLD		
		00146		B. WING		08	/14/2015	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - BA	ATTLE LAKE		IAVEN DRIVE				
			BATTLE LA	KE, MN 5651	5			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
22000	Continued From page trees which staff utilize report to the SA. He is practice was to immering altercation, and falls of the administrator state written policy." He not be interpreting the On 08/14/15, at 9:05 DON reviewed incide took herself to the bar "We know she took herself to the bar "We know she took herself to the bar she told us happened suspected a signification because of R3's chest. She stated the incident because R3' and stated that was we determine if it was rethe incident had not be because R3's care plead to the hospital it would they likely would not suspected injury, and nothing done. SUGGESTED METH The Director of Nurse could provide additional additional control of the provide additional could provide additional cou	red to determine we noticated the usual diately report to the origin, resident to rewhich resulted in firsted "we should be indicated the facile tools appropriated a.m. during intervient on 4/26/15. She throom and fell. She erself to bathroom and fell. She erself to bathroom aff with her, and the facility had not reless the pain and how facility had not reless care plan was forwhat the staff looked portable or not. She peen reported to the an was followed. She had treatment because at or shower, and id related to her distort the facility to trade to the facility to trade to the more traumal that we done anything that's why there we not so and the Social Wenal education to all	I facility le SA esident ractures. following fility may ely. ew the e stated R3 he stated, h, because hat's what y I at that olding her ported the flowed, ed at to he stated le SA She stated he SA She he stated he SA She state	22000				
	regarding reporting re immediate investigati of the procedures of	on to ensure imple	ementation					

Minnesota Department of Health

STATE FORM 6899 MQKK11 If continuation sheet 19 of 20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED					
			A. BUILDING.						
		00146	B. WING		08/14/2015				
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
GOOD SA	MARITAN SOCIETY - BA	ATTLE LAKE	NHAVEN DRIVE LAKE, MN 5651						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE				
22000	Continued From page	e 19	22000						
	Prevention Policy. T program could rando compliance.								
	TIME PERIOD FOR one (21) days.	CORRECTION: Twenty-							

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