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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MZF2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00021

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245600**

2.STATE VENDOR OR MEDICAID NO.
(L2) **336240000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BLACKDUCK**
(L4) **172 SUMMIT AVENUE WEST**
(L5) **BLACKDUCK, MN** (L6) **56630**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/16/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Aandal, HFE NE II 05/29/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 05/29/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 5/31/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/08/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5600

At the time of the standard survey completed February 22, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility was given an opportunity to correct before remedies were imposed.

On April 16, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 22, 2013, effective April 3, 2013. Therefore, the remedies outlined in our letter dated March 8, 2013, will not be imposed.
See the attached CMS-2567B form for the results of the April 16, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN# 24-5600 May 29, 2013

Ms. Angel Normandin, Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

Dear Ms. Normandin:

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

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

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

32 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 29, 2013

Ms. Angel Normandin, Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

RE: Project Number S5600022

Dear Ms. Normandin:

On March 8, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 22, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 16, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 3, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 22, 2013, effective April 3, 2013 and therefore remedies outlined in our letter to you dated March 8, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5600r113.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245600	A. Building B. Wing	4/16/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/03/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/03/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/03/2013**
ID Prefix **F0367** Reg. # **483.35(e)** LSC	Correction Completed **04/03/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/03/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** PK/sd	**Date:** 05/29/13	**Signature of Surveyor:** 11349	**Date:** 04/16/13
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/22/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MZF2

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00021

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245600**

2.STATE VENDOR OR MEDICAID NO.
(L2) **336240000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BLACKDUCK**
(L4) **172 SUMMIT AVENUE WEST**
(L5) **BLACKDUCK, MN** (L6) **56630**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/22/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, HFE - NEII 03/28/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 04/08/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 04/08/2013 CO.

MZF2

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5600
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on February 22, 2013, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit after April 3, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8298

March 8, 2013

Ms. Angel Normandin, Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, Minnesota 56630

RE: Project Number S5600022

Dear Ms. Normandin:

On February 22, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 302-6151

Fax: (218) 723-2359

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 April 3, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 3, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 22, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 22, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING _____ B. WING _____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED MAR 2 1 2013 MN Dept of Health Duluth	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning and incontinence care as directed by the written plan of care for 1 of 1 resident (R1) in the sample who required assistance with repositioning and incontinence care. Findings include: The plan of care (POC) dated 12/19/12, indicated R1 required total to extensive staff assistance with transferring, repositioning and toileting. The POC directed staff to turn, reposition or offload R1 every 1.5 to 2 hours and for staff to check / change incontinent product	F 282	OK 3/28/13 PLH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3-26-13

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

Good Samaritan Society®
BLACKDUCK

172 Summit Ave W
Blackduck, MN 56630

Phone: 218-835-4218
Fax: 218-835-6737
www.good-sam.com

F 282 Services by Qualified Person/Per Care Plan
SS=D

1) Resident R1 is receiving repositioning and incontinence care according to her care plan. R1's care plan has been reviewed and is up to date. All CNA's have been re educated and are aware of R1's care plan approaches with toileting and repositioning requirements.

2) All residents plans of care have been reviewed and updated for proper repositioning and incontinence care. Care plans for all residents will be reviewed with CNA's and licensed nursing staff.

3) Education provided to CNA's through inservices held on 3-19-2013 focused on the importance of following care plans. Kiosk training provided to ensure all CNA's know how to access care plan approaches for all residents.

4) Random observation audits of CNA's & documentation audits of toileting & repositioning will be completed by DNS or designee weekly X 4 weeks. Results of audits will be reported to facility quality assurance committee. Quality assurance committee will make further recommendations for ongoing audits. On going education will be provided to CNA's

5) Corrective action will be completed by 4-3-2013

In Christ's Love, Everyone Is Someone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING _____ B. WING _____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 when repositioned. On 2/20/13, at 6:09 p.m. Nursing assistant (NA) -A and NA-B were observed to assist R1 into bed. Both NA's stated they were unsure of what time R1 had been assisted into the chair. At 7:27 p.m. the director of nursing (DON) verified she had assisted R1 up from bed at 2:30 p.m. In addition, the DON verified R1 was not repositioned/offloaded or provided incontinent cares for 3 hours and 39 minutes. The DON also stated, the staff should have offloaded/repositioned and provided incontinent cares for R1 prior to supper as the POC directed. The DON verified R1's POC had not been followed. On 2/22/13, at 10:06 a.m. registered nurse-A stated, R1 should have been repositioned/offloaded and provided incontinence care every 1.5 to 2 hours as the POC directed. The facilities Pressure Ulcers: Skin Assessment And Prevention policy and procedure revised on 1/12, indicated residents who are unable to independently reposition themselves should be repositioned as often as directed by the POC.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		

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F 314 Treatments /services to Prevent/Heal Pressure Sores
SS=D

1) A new Positioning Data collection tool has been completed on Resident R1 and findings incorporated into her plan of care. Occupational Therapy has been consultant for proper pressure reduction device in wheel chair. Recommendations from OT have been applied and plan of care updated. Resident R1 is receiving repositioning and incontinence care according to her care plan. R1's care plan has been reviewed and is up to date. Resident R1 now has a low air loss alternating pressure air mattress on her bed to prevent potential pressure ulcers. R1's current pressure ulcer located on her toe continues to heal and area noted in facility 2567 on upper buttocks has resolved. All CNA's have been re educated and are aware of R1's care plan approaches with toileting and repositioning requirements.

2) All residents plans of care have been reviewed and updated for proper repositioning and incontinence care. Care plans for all residents will be reviewed with CNA's and licensed nursing staff.

6) Education provided to CNA's through in-services held on 3-19-2013 focused on the importance of following care plans. Kiosk training provided to ensure all CNA's know how to access care plan approaches for all residents.

7) Random observation audits of CNA's & documentation audits of toileting & repositioning will be completed by DNS or designee weekly X 4 weeks. Results of audits will be reported to facility quality assurance committee. Quality assurance committee will make further recommendations for ongoing audits. On going education will be provided to CNA's

8) Corrective action will be completed by 4-3-2013

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	245600	A. BUILDING _____ B. WING _____	02/22/2013

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F 314	Continued From page 2 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositining according to the assessed need for 1 of 1 resident (R1) who was identified at risk for pressure ulcers. Findings include: On 2/20/13, R1 was not repositioned/offloaded while in the wheelchair for 3 hours and 39 minutes. R1's diagnoses included dementia, severe osteoarthritis, a stroke and a right lower limb amputation. The significant change Minimum Data Set (MDS) dated 12/6/12, indicated R1 was cognitively intact with trouble concentrating on things and restlessness. The MDS also indicted R1 required total staff assistance for transferring and extensive assist of two staff for bed mobility. Additionally, the MDS identified R1 as at risk for pressure related ulcers and at the time of the MDS completion had an unstagable pressure ulcer. The Activities of Daily Living/Rehabilitation Care Area Assessment (CAA) dated 12/13/12, indicated R1 required two staff assistance and mechanical lift for transfers and bed mobility. The Pressure Ulcer CAA dated 12/13/12, indicated R1 required staff assist with bed mobility and transferring. The CAA also identified R1 had a	F 314		

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F 314	Continued From page 3 healing pressure area on the foot and indicated staff would assure R1 was offloaded and repositioned as needed. The MDS social service note dated 12/10/12, indicated R1 had dementia with cognitive deficits. The plan of care (POC) dated 12/19/12, indicated R1 had memory loss and impaired cognition with increased confusion and agitation. The POC indicated R1 had a history of and was at risk for the development of pressure ulcers. Additionally, the POC indicated R1 required one to two staff assistance for bed mobility and required total assistance with a mechanical lift for transferring. The POC also directed staff to turn, reposition and offload R1 every 1.5 to 2 hours. The Positioning Data Collection Tool form dated 11/5/12, indicated R1 had increased risk factors, a history of pressure sores and redness after sitting 1.5 to 2 hours. The form also indicated R1 required every 1.5-2 hours repositioning / offloading. The Braden Scale (a tool used for predicting pressure ulcer risk) dated 12/3/12, indicated R1 was at risk for the development of a pressure ulcer. The Interdisciplinary Progress Note (IDPN) dated 1/26/13, indicated R1's stage 1 (intact skin with non-blanchable redness) pressure ulcer to the right hip was 100% healed. The Wound Flow Sheet dated 2/9/13, indicated R1's left lateral big toe wound measured 0.2 x 0.1 centimeter (cm). The sheet indicated a Band-Aid	F 314		

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F 314	Continued From page 4 was applied. The IDPN dated 2/20/13, indicated R1 had a healing pin point open area and directed staff to continue to follow the POC. The Toileting / Repositioning Schedule form dated 2/20/13, utilized by the nursing aides, indicated R1 was last turned / repositioned / toileted at 2:30 p.m. On 2/20/13, at 5:24 p.m. R1 was observed in the wheelchair wheeling herself from the dining room. At 6:00 p.m. R1 was observed to remain in the wheelchair sitting in her room doorway watching resident / staff activity. At 6:09 p.m. nursing assistant (NA)-A and NA-D was observed providing evening cares. NA-A stated R1 had a tendency to get skin sores. At 6:22 p.m. NA-A and NA-D were observed to transfer R1 into bed via a mechanical lift. R1's brief was observed to be saturated, heavy with urine. A deep red area on R1's upper left coccyx/buttock area and lower right gluteal crease was observed. NA-A applied Aquaphor cream to the areas. The redness did not decrease with the gentle tactile stimulation. A Band-Aid was also observed on R1's left lateral outer big toe. NA-A was observed to loosen the Band-Aid which revealed approximately a quarter size pink area with a central fine pin point open area. NA-A reapplied the Band-Aid. Both NA-A and NA-D stated, R1 had a history of skin breakdown, pressure areas. At 6:33 p.m. cares were completed, R1 was positioned on her back with pillows under lower extremities. NA-stated, R1 was assisted up for supper around 4:00 p.m. but stated she wasn't for sure.	F 314		

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F 314	Continued From page 5 At 6:40 p.m. NA-A stated, nursing staff documented the time a resident was repositioned / toileted on a sign off form that hung in the utility room. The sign off form titled Toileting/Repositioning Schedule dated 2/20/13, indicated R1 was last toileted repositioned at 2:30 p.m. NA-A verified R1 had not been repositioned since 2:30 p.m. However, NA-A added, she had thought R1 was assisted up at 4:00 p.m. At 6:42 p.m. R1's upper buttock area was observed to be slightly red/pink. NA-A also stated R1's skin usually returns to normal after being laid down. At 7:03 p.m. NA-B stated, the nurses assisted R1 up in the wheelchair about 3:15 p.m. and that she remained in the wheelchair until after supper. At 7:27 p.m. the director of nursing (DON) verified she had assisted R1 up from bed at 2:30 p.m. The DON also verified R1 was at risk for pressure related ulcers. In addition, the DON verified R1 was not repositioned/offloaded for 3 hours and 39 minutes. Additionally, the DON stated, the staff should have laid R1 back down in bed to provide offloading/repositioning prior to supper. On 2/22/13, at 8:26 a.m. NA-C verified R1's coccyx did get red at times, however, did usually go away once laid down. NA-C also stated, R1 required every 2 hour repositioning assistance. At 10:06 a.m. registered nurse (RN)-A verified R1 was prone to pressure related ulcers and should have been turned and repositioned 1.5 to 2 hours	F 314		

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F 314	Continued From page 6 according to the POC. The facilities Pressure Ulcers: Skin Assessment And Prevention policy and procedure revised on 1/12, (Item #6) indicated residents who are unable to independently reposition themselves should be repositioned as often as directed by the POC.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 1 resident (R1) in the sample, received timely assistance with incontinence care according to the assessed need. Findings include: On 2/20/13, R1 was not provided with incontinence care for 3 hours and 39 minutes. R1's diagnoses included dementia, severe osteoarthritis, a stroke and a right lower limb	F 315		

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F315 No Catheter, Prevent UTI, Restore Bladder
SS=D

1) Resident R1 is receiving repositioning and incontinence care according to her care plan. R1's care plan has been reviewed and is up to date. All CNA's have been re educated and are aware of R1's care plan approaches with toileting and repositioning requirements.

2) All residents plans of care have been reviewed and updated for proper repositioning and incontinence care. Care plans for all residents will be reviewed with CNA's and licensed nursing staff.

3) Education provided to CNA's through inservices held on 3-19-2013 focused on the importance of following care plans. Kiosk training provided to ensure all CNA's know how to access care plan approaches for all residents.

4) Random observation audits of CNA's & documentation audits of toileting & repositioning will be completed by DNS or designee weekly X 4 weeks. Results of audits will be reported to facility quality assurance committee. Quality assurance committee will make further recommendations for ongoing audits. On going education will be provided to CNA's

5) Corrective action will be completed by 4-3-2013

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F 315	Continued From page 7 amputation. The significant change Minimum Data Set (MDS) dated 12/6/12, indicated R1 was cognitively intact with trouble concentrating on things and restlessness. The MDS also indicted R1 required extensive assist of two staff for toileting needs. The MDS also indicated R1 was frequently inconintient of urine. The Activity Functional / Rehabilitation Potential Care Area Assessment (CAA) dated 12/13/12, indicated R1 required 2 staff for toileting needs. The Urinary Incontinence CAA dated 12/13/12, indicated R1 was often incontinent of bladder and required staff assist with toileting and pericares. The plan of care (POC) dated 12/19/12, indicated R1 had stress incontinence with the inability to toilet self and cleanse peri area. The POC also indicated R1 would ask for the bed pan at times. The POC directed staff to assist R1 to use the bedpan and check and change incontinent product when repositioned. The Bladder Assessment form dated 12/4/12, indicated R1 had long standing stress/mixed incontinence with some control present. The form indicated R1 utilized a bed pan at times and other times was incontinent with no specific pattern noted. The Form also indicated R1 voided in large amounts. The form also indicated R1 required scheduled checking and changing of incontinent brief and was to be offered the bed pan every two hours with repositioning. Nurses notes dated 12/8/12, indicated R1 required extensive staff assist with all cares and was frequently incontinent of bladder. The Nursing Documentation form dated 1/3/13	F 315		

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F 315	Continued From page 8 indicated R1 was mostly incontinent of bladder and utilized a bed pan. On 2/20/13, at 5:24 p.m. R1 was observed wheeling self from the dining room. At 6:00 p.m. R1 was observed to remain in the wheelchair, sitting in own doorway watching resident/staff activity. At 6:09 p.m. nursing assistant (NA)-A and NA-D was observed to provide evening cares. At 6:22 p.m. both NA's were observed to transfer R1 via the mechanical lift into bed. R1's incontinent product was observed to be saturated and heavy with urine. NA-A stated, she had thought R1 was last toileted about 4:00 p.m. but stated she wasn't sure. At 6:40 p.m. NA-A stated, nursing staff would document the time a resident was toileted on the sign off form hanging in the utility room. The sign off form titled Toileting/Repositioning Schedule dated for 2/20/13, indicated R1 was last toileted at 2:30 p.m. NA-A stated, according to the form R1 was last toileted at 2:30 p.m. At 7:03 p.m. NA-B stated, R1 was up in the wheelchair when she arrived on the floor at about 3:15 p.m. and verified R1 had remained in the wheelchair without cares until she was assisted into bed. At 7:27 p.m. the director of nursing (DON) stated, she and another nurse had assisted R1 into the wheelchair at 2:30 p.m. and had expected the staff to have laid R1 down and provide incontinent cares prior to supper. The DON verified R1 was	F 315		

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F 315	Continued From page 9 not provided incontinence / toileting cares for 3 hours and 39 minutes. On 2/22/13, at 8:26 a.m. NA-C verified R1 required every 2 hour toileting assistance. At 10: 06 a.m. registered nurse (RN)-A stated R1 required staff assistance with toileting/incontinence care before and after meals and every 2 hours in between. RN-A also stated, at times R1 would also request to use the bed pan. At 10:46 a.m. the DON verified R1 was incontinent of urine. The DON stated, R1 was to be toileted and/or offered the bed pan every 2 hours when repositioned and when R1 requested. The DON stated she would expect the staff to follow the POC as directed. The Toileting Programs procedure revised 1/11, indicated an appropriate toileting program should be implemented based on the type of incontinence and the assessed need.	F 315		
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve the prescribed diets for 3 of 5 (R11, R34, R32) residents in the sample observed during meal service.	F 367		

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F TAG 367 THERAPEUTIC DIET PRESCRIBED BY PHSYCIAN
SS = E

1. Residents R11, R34 & R32 are receiving their prescribed diets at all meals. Dietary in-service conducted by consultant dietitian was held on 3/13/13 to educate all dietary staff on following prescribed physician diet orders and how to read diet spreadsheets for each ordered diet. Competencies will be completed on all cooks by the dietary manager by 3/20/13. Consultant Dietitian to review all resident diet orders and request liberalization of diets due to restrictive diets not indicated nor necessary in long term care when providing a home-like dining environment.

2. All new residents' diet orders will be reviewed by Consultant Dietitian and clarified with physician to accommodate liberalized diets provided.

3. Any new staff hired will be oriented to above policies and procedures.

4. Audits will be done weekly x 3 months by dietary manager and/or Consultant Dietitian to ensure proper diets and portion sizes are served. Results to be reviewed at QA committee. Quality assurance committee will make further recommendations for ongoing audits

5. All corrective action will be completed by 4/3/13.

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F 367	Continued From page 10 Findings include: Meal tray service was observed on 2/21/13, from 11:30 a.m. to 12:30 a.m. with Cook-A. R11 had a physician prescribed diet dated 1/28/13, for a "Renal" diet. R11's meal card indicated the following: Low Fat, Low Cholesterol; Renal Diet; Fork mashable foods well moistened; smaller portions; level 2 ground meat. During the noon meal on 2/21/13, R11 received: 1/2 cup of mashed potatoes; gravy with 2 ounces of meat; 1/2 cup of cooked carrots, and cherry whip. Review of the renal diet menu revealed that the resident was supposed to receive the following: A regular roast beef sandwich with 2 slices of bread, NO potatoes but substitute buttered spiral noodles; 1/2 cup buttered corn; and cherry whip. R34 had a physician prescribed diet dated 2/11/13, for "low sodium." R34's meal card indicated the following diet "reduced sodium." During the noon meal on 2/21/13, the resident received: 1/2 of a hot roast beef sandwich, no gravy, 1/2 cup of carrots, and cherry whip. Review of the low sodium diet menu revealed that the resident was supposed to receive a hot roast beef sandwich with 3 ounces of meat and gravy on one slice of bread; 1/2 cup of buttered corn; and cherry whip. R32 had a physician order for "cardiac" diet dated 1/22/13. R32's meal card indicated the following: Cardiac-Low fat No added salt. Avoid: Nuts, Seeds, Popcorn, Pea's, Corn, spicy foods." During the noon meal on 2/21/13, the resident received: 1/2 of a hot roast beef sandwich, gravy, 1/2 cup of carrots, and cherry whip. Review of the	F 367		

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F 367	Continued From page 11 low sodium, low cholesterol diet menu revealed that the resident was supposed to receive a hot roast beef sandwich with 3 ounces of meat and NO gravy on one slice of bread; 1/2 cup of buttered corn; and cherry whip. On 2/21/13, at 12:13 p.m. Cook-A stated, she did not know which menu exchanges to follow for all of the diets when serving the resident's meals. Cook-A stated she had not been trained on how to serve the correct diet to each resident. On 2/22/13, at 11:07 a.m. the registered dietician (RD) and dietary manager (DM) both stated they were unaware that Cook-A did not know how to appropriately use the diet exchanges in order to serve the prescribed diet to the residents. The RD and DM both verified Cook-A had been trained and shown how to serve the appropriate diet upon hire almost one year previous. No further information was provided.	F 367		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		

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F TAG 371 FOOD PROCURE, STORED, PREPARED, SERVE – SANITARY
SS = F

1. Dietary in-service conducted by the facility Consultant Dietitian held on 3/13/13 to educate all dietary staff on proper hand washing, glove use, and proper storing of dishes, pots and pans. Current policies and procedures reviewed.

2. All residents have potential to be affected.

3. All new staff will be properly educated on hand washing, glove use, and storing of dishes, pots and pans.

4. Observation and audits will be done randomly of hand washing, glove use, and proper storage of dishes, pots and pans by dietary manager and/or Consultant Dietitian x 12 weeks. All results will to be reviewed by the QA committee for further recommendation. Quality assurance committee will make further recommendations for ongoing audits

5. Corrective action will be completed by 4/3/13.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING _____ B. WING _____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 Based on observation and interview, the facility failed to ensure hand hygiene was maintained during 1 of 1 meal service observation and failed to ensure large metal bowls and pans were stored in a sanitary manner. This practice had the potential to affect all 30 residents residing in the facility. Findings include: Food service was observed on 2/21/13, from 11:30 a.m. to 12:30 p.m. At the beginning of the meal service Cook-A was observed wearing gloves. Throughout the meal serving process Cook-A was observed to open the refrigerator, retrieve a container of cottage cheese, dish up the cottage cheese and return the container to the refrigerator. Cook-A was also observed to touch two cupboard handles, open and close them and touch the toaster. During the serving of 30 resident meal trays, Cook-A was observed to touch individual bread slices and place them on the each resident plate with the same gloved hands. Throughout the meal service observation, Cook-A had not changed her gloves or wash her hands after contaminating the gloves with the aforementioned items. A tour of the kitchen was performed on 2/22/13, at 1:00 p.m. during which it was noted that eight bowls and pans were stored wet. On 2/22/13, at 1:16 p.m. the dietary manager (DM) stated, that hand hygiene and/or glove change should be performed after touching any unclean surfaces when serving food. Additionally, the DM verified cooking pans/bowels should not have been stored wet.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING _____ B. WING _____	02/22/2013

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F 371	Continued From page 13 No further information was provided.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/21/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST** **BLACKDUCK, MN 56630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Blackduck 01 Main Building was found 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. Good Samaritan Society Blackduck is a 1-story building built at three different times. The first and major portion of the building was built in 1970, is 1-story with a basement and was determined to be Type I(332) construction. In 1996 a dining room/ PT addition was constructed to the north of the original building. This addition is 1-story, with a basement and was determined to be type II (111) construction. In 2009 a connecting link and activities addition was constructed to the north of the dining room. It is separated with a 2-hour fire barrier, 1-story, no basement , Type V(111) construction facility is divided into 3 smoke zones with 30-minute fire barriers. The facility has a complete automatic fire sprinkler system with quick response heads, installed in accordance with NFPA 13 The Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes smoke detection throughout the	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/21/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 corridor system and in all common areas, which is installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have single station battery operated smoke detectors and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 30 beds had a census of 30 at the time of the survey. The facility main building and addition comply with the construction types allowed and was surveyed as one building of Type II (111) construction. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **02 - ACTIVITIES ADDITION** B. WING _____	**02/21/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST** **BLACKDUCK, MN 56630**

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K 000	INITIAL COMMENTS FIRE SAFETY 02 Connecting Link/ Activities A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Blackduck 02 Connecting Link/ Activities was found 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. Good Samaritan Society Blackduck is a 1-story building built at three different times. The first and major portion of the building was built in 1970, is 1-story with a basement and was determined to be Type I(332) construction. In 1996 a dining room/ PT addition was constructed to the north of the original building. This addition is 1-story, with a basement and was determined to be type II (111) construction. In 2009 a connecting link and activities addition was constructed to the north of the dining room. It is separated with a 2-hour fire barrier, 1-story, no basement , Type V(111) construction facility is divided into 3 smoke zones with 30-minute fire barriers. The facility has a complete automatic fire sprinkler system with quick response heads, installed in accordance with NFPA 13 The Standard for Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes smoke detection throughout the	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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	245600	A. BUILDING **02 - ACTIVITIES ADDITION** B. WING _____	**02/21/2013**

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