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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P7JT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00755

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245549**

2. STATE VENDOR OR MEDICAID NO. (L2) **477840500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE**
(L4) **745 BASINGER MEMORIAL DRIVE**
(L5) **MOUNTAIN LAKE, MN** (L6) **56159**

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 **11/3/2017** (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) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 11/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/30/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245549 November 30, 2017

Mr. Timothy Swoboda, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

Dear Mr. Swoboda:

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 October 26, 2017 the above facility is certified for:

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.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 30, 2017

Mr. Timothy Swoboda, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

RE: Project Number S5549029

Dear Mr. Swoboda:

On October 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 5, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 3, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 6, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 26, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 5, 2017, effective October 26, 2017 and therefore remedies outlined in our letter to you dated October 20, 2017, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P7JT

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(L4) **745 BASINGER MEMORIAL DRIVE**
(L5) **MOUNTAIN LAKE, MN** (L6) **56159**

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)

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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) **09/30**

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To (b) :

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
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___ 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

* Code: **B*** (L12)

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17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 10/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/13/2017 (L20)

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

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

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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
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30. REMARKS

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32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 20, 2017

Mr. Timothy Swoboda, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

RE: Project Number S5549029

Dear Mr. Swoboda:

On October 5, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

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 November 14, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 January 5, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by April 5, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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
	245549	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 On October 2, 3, 4 and 5th, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 242		10/26/17

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

Electronically Signed | 10/27/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 1 facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to respect resident choice of meal times for 1 of 1 dependent resident (R19) observed who was assisted after all the residents finished their meals. Findings include: Review of R19's medical record identified diagnoses include: dementia, weakness and a history of weight loss. R19 required total staff assistance with transfer to the dining room and required extensive assistance with eating. R19 was non-verbal but occasionally made yes or no comments. R19 was observed on 10/2/17, from 3:40 p.m. to 4:34 p.m. asleep in the Geri-chair (high back wheelchair) in the lounge area located in front of the nurse's station. R19 was again noted at that same location, in the same seated position at 5:30 p.m., 6:00 p.m. and 6:22 p.m. At 6:27 p.m., R19 was finally assisted to the dining room by staff for the supper meal. At 7:30 p.m., R19 was observed reaching for her full tray of food, unable to feed herself, totally dependent upon staff for food. Staff then began to assist with feeding R19. On 10/3/17, at 5:23 p.m. an unidentified staff member asked NA-A over her walkie-talkie "Can I bring room [R19] down to eat?" NA-A replied "Don't bring [R19]." Another staff member also requested to transport another resident to the dining room but NA-A did not respond. When interviewed on 10/3/17, at 5:48 p.m.	F 242	F242 SELF DETERMINATION – RIGHT TO MAKE CHOICES Due to her dementia, Resident #19 is not able to make her own choices. Staff discussed resident with her daughter to determined resident needs regarding meals, based on daughter's input. All other residents who are not able to express their own desires about choices in meal assistance have been identified and we have contacted their family as well. Nursing staff were educated at an inservice of the professional staff on 10/12/2017, a nursing assistant inservice on 10/17/2017, and one on one conversations or individual memo delivered to those who could not attend these meetings prior to 10/26/2017 on the need to be aware of resident choices and dignity at all times. A meeting of the Performance Improvement Project (PIP) team including nursing assistants and dietary staff for meal assistance has met to complete a Root Cause Analysis for these issues. Initial recommendations from this analysis have been instituted. Ongoing audits of 2-3 meals per week for the next month and then one meal per week for an additional month, will be conducted by the Director of Nursing or her designee for implementation of these recommendations. Additional PIP meetings will be held to evaluate effectiveness of initial recommendations and make changes as necessary. All results will be reported at the monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 242	Continued From page 2 licensed practical nurse (LPN)-B indicated that during meal time, 2 NA's are assigned to assist residents located in their rooms and 2 staff are assigned to assist resident's located in the dining room. It was observed that R19 had not yet been brought down to the meal yet at this time, 5:48 p.m. LPN-B agreed that waiting to bring resident's to the dining room who cannot express their desire/choice is based solely on staff convenience. LPN-B also agreed that dependent resident were not offered a meal time based on loss of appetite, weight loss or previous lifestyle. LPN-B indicated the evening meal had less available staff than during a day shift meal. On 10/3/17, at 5:56 p.m. and 6:09 p.m. R19 had not yet been brought into the dining room for the meal. At 6:16 p.m. NA-B left the area to transport R19 to the dining room. Dietary staff were clearing plates in the dining room at this time. No other resident's were eating their meal at this time. R19 was assisted with the meal without any other resident's in the area. When interviewed on 10/3/17, 6:25 p.m. NA-A explained that over the past few months four residents have required more assistance and required total assistance; adding, additional staff would be helpful. NA-A explained she advised staff not to bring R19 down as they were unable to assist with eating. NA-A explained they only assist one table with dependent resident's at a time; consequently, staff was instructed not to transport residents into the dining room. Interview on 10/4/17 at 10:34 a.m. FM-B (R19) indicated she would often visit on Sundays, but also during the week. FM-B explained that R19 had declined in eating ability in the past four or so	F 242	QAPI meeting for review and decisions on further action if necessary will be made by the committee. Completion date 10/26/2017	

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	245549	A. BUILDING _____ B. WING _____	10/05/2017

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F 242	Continued From page 3	F 242		

months and now required total assistance. FM-B stated she used to take R19 to supper at 5:00 p.m. but stopped as her food would sit in front of her and get cold, waiting for staff assistance. FM-B stated she would wait until 5:20 p.m. so staff would be available at that time. FM-B indicated she was unaware that R19 had been assisted at the end of the meal (6:30 p.m.) FM-B indicated R19's usual routine eating times were 7:00 a.m., noon and 5:00 p.m. ever since she could recall.

When interviewed on 10/5/17, at 1:49 p.m. the director of nursing (DON) indicated, "There are times when we have had to shift staff to accommodate a need, for instance call lights." The DON explained the facility was conducting a feeding assistance QA [quality assurance] based on a verbal complaint related to an arthritis resident. The DON indicated the resident was upset because staff left to assist another resident with eating. As a result, it was decided to bring residents to the dining room in shifts instead of adding extra staff. This was initiated on May, 23, 2017 and "we haven't done anything with it yet." The DON agreed it was the non-verbal dependent residents who were transported later into the dining room. When questioned how non-verbal residents were given the choice to come later to dining, the DON stated "They haven't expressed it." The DON stated she felt anytime between 5:00 p.m. and 6:30 p.m. was acceptable to wait for a meal (open dining), regardless of choice.

The DON further indicated the four scheduled evening NA's take breaks at: 4:30 p.m., 5:00 p.m., 5:30 p.m. and 6 p.m. since they do not have access to the kitchen after the supper meal;

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F 242	Continued From page 4 therefore, staff start taking breaks 2 hours after the start of the shift. The DON agreed the times of the breaks accommodated staff convenience and not resident choice. The DON agreed the open dining had considered the choices of resident's able to verbalize but had not considered the preferences of non-verbal residents, such as R19. Review of the the facility's September 2017 Resident Choice Dining policy indicated its purpose was to ensure resident choice in dining and meal times. In cases where the resident has dementia, or other barriers or challenges to providing information related to food preferences, document efforts to learn preferences (e.g. contact family or close friend.)	F 242		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide proper toenail services for 1 of 1 resident (R29) reviewed who required staff assistance with foot care. Findings include: During observation and interview with an interpreter on 10/3/17, at 10:31 a.m. R29 complained of foot pain. R29 stated her son used to trim her toenails, but he had not done so in a long time. R29 indicated she had asked nursing	F 312	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Resident #29 was seen immediately at her clinic to determine if there were any issues with her toenails that required attention. No issues were noted and a recommendation was made by the C.N.P. to see the podiatrist at the next visit. This was accomplished on 10/18/2017. All other residents who did not see the podiatrist on 10/18/2017 were assessed for the condition of their toenails and any	10/26/17

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F 312	Continued From page 5 staff to trim her toenails; however, no one had trimmed them. It was noted she had long, thick and yellow colored toenails. R29's right great toenail was jagged in appearance and she winced upon movement of her feet. Review of R29's record indicated the following diagnoses: polyneuropathy (disease affecting nerve sensation in limbs), hemiplegia (paralysis on one side of the body), epilepsy, stroke and Type 2 diabetes. R29 received aspirin (ASA) therapy related to her history of stroke which increased her likelihood of bleeding. It was noted that R29 was not currently being pharmacologically treated for diabetes. R29's current care plan indicated she required 1 staff assistance with personal hygiene and bathing care. R29 required total assistance for activities of daily living, such as dressing, transfer and toilet use. The care plan lacked any reference to the diabetes diagnosis of diabetes nor any necessary bleeding precautions related to aspirin therapy. Interview on 10/3/17, at 4:00 p.m. with licensed practical nurse (LPN)-A indicated she had been employed at the facility for 13 years. LPN-A stated R29 received nail care during bath time on Wednesday evenings from the nursing assistants (NA's). LPN-A stated being unaware R29 had a diabetes diagnosis. When interviewed on 10/3/17, at 4:15 p.m. the director of nursing (DON) indicated she was made aware of R29's desire for podiatry services by the interpreter and the registered nurse (RN) coordinator. The DON also confirmed being unaware of the diabetic diagnosis. The DON stated it was the expectation that licensed nursing staff were to trim R29's toenails especially with a	F 312	need for immediate intervention. Nails were trimmed as needed and those with thickened nails are being referred, pending resident or family approval to the podiatrist. Nursing staff were educated at an inservice of the professional staff on 10/12/2017, a nursing assistant inservice on 10/17/2017, and also one on one conversations or individual memo delivered to those who could not attend these meetings prior to 10/26/2017. Discussed was the need to trim toenails of all residents at the time of their shower. Those residents who are diabetic or have thickened and difficult are to be referred immediately to the charge nurse. All care plans were evaluated to insure approaches for diabetic nail care were present on the care plan and thus available to the nursing assistants. If the charge nurse, upon investigation of the resident's nails, does not feel she is able to safely trim the nails then a referral will be made to the either the physician or the podiatrist. Audits of 2-3 resident toenails will be conducted by the Director of Nursing or her designee, every month for 2 months and then randomly thereafter to insure compliance. All audit results will be reported at the monthly QAPI meeting for review and decisions on further action needed, if necessary. Completion date 10/26/2017	

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F 312	Continued From page 6 diabetic diagnosis. The DON confirmed she was unaware that staff weren't trimming R29's toenails as needed. Review of the February 2013 Care Plan policy indicated residents were to receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Review of the September 2012 Podiatric Care policy indicated residents were to receive treatment by qualified persons for foot disorders as well as skin and nail conditions of the feet. In addition, preventative care was to be given to avoid foot problems in diabetic residents and in residents with circulatory problems.	F 312		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy	F 328		10/26/17

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F 328	Continued From page 7 services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 328	F328 TREATMENT/CARE FOR	

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F 328	Continued From page 8 review, the facility failed to offer and/or provide proper foot care for 1 of 1 resident (R29) reviewed who had untrimmed toenails and had a diagnoses of diabetes and neuropathy. Findings include: During observation and interview with an interpreter on 10/3/17, at 10:31 a.m. R29 complained of foot pain. R29 stated her son used to trim her toenails, but he had not done so in a long time. R29 indicated she had asked nursing staff to trim her toenails; however, no one had trimmed them. It was noted she had long, thick and yellow colored toenails. R29's right great toenail was jagged in appearance and she winced upon movement of her feet. Review of R29's record indicated the following diagnoses: polyneuropathy (disease affecting nerve sensation in limbs), hemiplegia (paralysis on one side of the body), epilepsy, stroke and Type 2 diabetes. R29 received aspirin (ASA) therapy related to her history of stroke which increased her likelihood of bleeding. It was noted that R29 was not currently being pharmacologically treated for diabetes. R29's current care plan indicated she required 1 staff assistance with personal hygiene and bathing care. R29 required total assistance for activities of daily living, such as dressing, transfer and toilet use. The care plan lacked any reference to the diabetes diagnosis of diabetes nor any necessary bleeding precautions related to aspirin therapy. Interview on 10/3/17, at 4:00 p.m. with licensed practical nurse (LPN)-A indicated she had been employed at the facility for 13 years. LPN-A stated R29 received nail care during bath time on	F 328	SPECIAL NEEDS Resident #29 was seen immediately at her clinic to determine if there were any issues with her toenails that required attention. No issues were noted and a recommendation was made by the C.N.P. to see the podiatrist at the next visit. This was accomplished on 10/18/2017. All other residents who did not see the podiatrist on 10/18/2017 were assessed for the condition of their toenails and any need for immediate intervention. Nails were trimmed as needed and those with thickened nails are being referred, pending resident or family approval to the podiatrist. Nursing staff were educated at an inservice of the professional staff on 10/12/2017, a nursing assistant inservice on 10/17/2017, and also one on one conversations or individual memo delivered to those who could not attend these meetings prior to 10/26/2017. Discussed was the need to trim toenails of all residents at the time of their shower. Those residents who are diabetic or have thickened and difficult are to be referred immediately to the charge nurse. All care plans were evaluated to insure approaches for diabetic nail care were present on the care plan and thus available to the nursing assistants. If the charge nurse, upon investigation of the resident's nails, does not feel she is able to safely trim the nails then a referral will be made to the either the physician or the podiatrist. Audits of 2-3 resident toenails will be conducted by the Director of Nursing or her designee, every month for 2 months and then randomly thereafter to	

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F 328	Continued From page 9 Wednesday evenings from the nursing assistants (NA's). LPN-A stated being unaware R29 had a diabetes diagnosis. R29 received a standing physician's order for podiatry services upon her admission to the facility on 4/4/14. When interviewed on 10/3/17, at 4:15 p.m. the director of nursing (DON) indicated she was made aware of R29's desire for podiatry services by the interpreter and the registered nurse (RN) coordinator. The DON also confirmed being unaware of the diabetic diagnosis. The DON stated it was the expectation that licensed nursing staff were to trim R29's toenails especially with a diabetic diagnosis. The DON confirmed she was unaware that staff weren't trimming R29's toenails as needed. The DON confirmed she was unaware that staff weren't trimming R29's toenails and that Podiatry services were to be given per standing order for any diabetic resident in the facility. Review of the February 2013 Care Plan policy indicated residents were to receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Review of the September 2012 Podiatric Care policy indicated residents were to receive treatment by qualified persons for foot disorders as well as skin and nail conditions of the feet. In addition, preventative care was to be given to avoid foot problems in diabetic residents and in residents with circulatory problems.	F 328	insure compliance. All audit results will be reported at the monthly QAPI meeting for review and decisions on further action needed, if necessary. Completion date 10/26/2017	
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		10/26/17

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F 329	Continued From page 10 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 329		

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F 329	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to monitor the effectiveness of a cholesterol lowering medication (pravastatin), failed to monitor for the side effects of an anti-hypertensive medication (Lisinopril) and failed to provide adequate indications for concurrent use of aspirin and Coumadin for 2 of 5 residents (R50, R62) reviewed for unnecessary medications. Findings include: R50's signed physician orders dated 10/4/17, included a current order for pravastatin 20 milligrams (mg) by mouth one time daily for vasculopathy (any disorder of the blood vessels). The physician order for pravastatin included a start date of 4/25/17. R50's care plan last revised 5/17/17, indicated: The resident has altered cardiovascular status related to CAD (coronary artery disease), A-fib (atrial fibrillation), and hyperlipidemia (high level of lipids in blood). Review of R50's medical record did not include evidence a recent lipid panel had been completed to monitor the effectiveness of pravastatin, (treats high cholesterol and triglyceride levels). The most recent lipid panel located in the record was dated 6/16/15. Review of the consulting pharmacist's Drug Regimen Review Report dated 6/26/17, included a recommendation for yearly lab draw for complete blood count (CBC), lipids and liver function tests (LFT's). The physician response	F 329	F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS The physician for Resident #50 was contacted and an order was obtained to draw a Lipid Panel now and then yearly thereafter. This was drawn on 10/16/2017. The physician for Resident #62 was contacted for clarification on the need for both Aspirin and Coumadin as well as the need for the potassium to be drawn. The order for the potassium was obtained and was drawn on 10/25/2017. The physician wrote his rationale for continuing both the ASA and the Coumadin. A letter was sent to all attending physicians, explaining the need to promptly review and return the pharmacy recommendations and also provide a rationale for any decision made. It was explained to each physician that the facility would do its best to provide sufficient documentation, along with the pharmacy recommendations, for them to make an informed decision. The letter also informed the physicians that we would return all recommendation sheets that were not addressed adequately for continued review. All current pharmacy recommendations were evaluated and those without appropriate responses were returned to the physician for further comment and included additional information as needed. All September reports have been returned to the facility and have been addressed. Professional nursing staff were inserviced on 10/12/2017 on the need to monitor any	

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F 329	Continued From page 12 indicated: Make sure he has CBC, CMP (comprehensive metabolic panel which includes LFT's) yearly. However, the physician response did not include a rationale for not ordering a lipid panel. The Drug Regimen Review Report dated 9/29/17, included: Please define how often lipids should be monitored for patient on pravachol (pravastatin). When interviewed on 10/5/17, at 9:27 a.m. registered nurse (RN)-A confirmed R50's last lipid panel was completed on 6/16/15. RN-A further confirmed the physician did not respond to the pharmacy recommendation dated 6/26/17, related to (r/t) a yearly lipid panel nor gave rationale as to why a lipid panel was not ordered. When interviewed on 10/5/17 at 11:02 a.m. the director of nursing confirmed R50's medical record did not include documentation to support the rationale for not ordering a lipid panel to monitor the effectiveness of pravastatin. Document review of the diagnoses list dated 10/3/17, for R62 identified: cervical spine (C-2) fracture, atrial fibrillation, hyperlidemia and hypertension. Review of the document titled Physician orders dated 10/4/17, the following was noted for R62: Aspirin 81 mg daily for atrial fibrillation; Coumadin 1.5 mg daily; and Lisinopril 10 mg daily. The document titled, Pharmacy Review dated 6/27/17, and 7/31/17, revealed: recommend checking potassium (K+) level with use of Lisinopril and re-evaluate the need for Aspirin and Coumadin for atrial fibrillation, document need for both or consider d/c (discontinue), consider d/c for aspirin.	F 329	pharmacy recommendation returned from the physician for new orders and provide any additional information requested by the physician in a timely manner. The Director of Nursing or her designee will audit all future pharmacy recommendation sheets to insure they are returned, addressed by the physician in a timely manner, and contain complete responses. All audit results will be reported at the monthly QAPI meeting for review and decisions on further action needed, if necessary. Completion date 10/26/2017	

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F 329	Continued From page 13 The physician's only response dated 7/6/17, indicated "please continue". The physician's response lacked a rationale addressing the concurrent use of Aspirin and Coumadin. Document review lacked completion of the recommended potassium level to monitor for a high potassium level related to ongoing administration of Lisinopril. When interviewed on 10/4/17, at 11:04 a.m. nurse manager (NM)-A confirmed the lab (K+ level) had not been completed for R62 per pharmacy recommendation to monitor for side effects. In addition, review of the medical record also lacked evidence the potassium level had been monitored. When interviewed on 10/5/17, at 9:27 a.m. the director of nursing (DON) confirmed the potassium level had not been monitored while R62 had been on Lisinopril. The DON confirmed that R62 had concurrent administration of Aspirin and Coumadin without adequate indications for use especially since the physician had not responded with the rationale for continuing both medications. Upon interview with the consulting pharmacist on 10/5/17 at 10:39 a.m. it was learned it is important to monitor the potassium level with the ongoing order for Lisinopril, which can cause hyperkalemia (high level of potassium), a dangerous side effect.	F 329		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		10/26/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING _____ B. WING _____	10/05/2017

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F 428	Continued From page 14 c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending	F 428		

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F 428	Continued From page 15 physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the physician responded to the recommendations of the pharmacist related to monitoring the effectiveness of a cholesterol lowering medication (pravastatin), to monitor for the side effects of an anti-hypertensive medication (Lisinopril) with checking the potassium blood level and to indicate rationale for concurrent use of Aspirin and Coumadin for 2 of 5 residents (R50, R62) reviewed for drug irregularities. Findings include: R50's signed physician orders dated 10/4/17, included a current order for pravastatin 20 milligrams (mg) by mouth one time daily for vasculopathy (any disorder of the blood vessels). The physician order for pravastatin included a start date of 4/25/17. R50's care plan last revised 5/17/17, indicated: The resident has altered cardiovascular status related to CAD (coronary artery disease), A-fib (atrial fibrillation), and hyperlipidemia. Review of R50's medical record did not include	F 428	F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR The physician for Resident #50 was contacted and an order was obtained to draw a Lipid Panel now and then yearly thereafter. This was drawn on 10/16/2017. The physician for Resident #62 was contacted for clarification on the need for both Aspirin and Coumadin as well as the need for the potassium to be drawn. The order for the potassium was obtained and was drawn on 10/25/2017. The physician wrote his rationale for continuing both the ASA and the Coumadin. A letter was sent to all attending physicians, explaining the need to promptly review and return the pharmacy recommendations and also provide a rationale for any decision made. It was explained to each physician that the facility would do its best to provide sufficient documentation, along with the pharmacy recommendations, for them to make an informed decision. The letter also informed the physicians that we would return all recommendation sheets that were not addressed adequately for	

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F 428	Continued From page 16 evidence a recent lipid panel had been completed to monitor the effectiveness of pravastatin. The most recent lipid panel located in the record was dated 6/16/15. Review of the consulting pharmacist's Drug Regimen Review Report dated 6/26/17, included a recommendation for yearly lab draw for complete blood count (CBC), lipids and liver function tests (LFT's). The physician response indicated: Make sure he has CBC, CMP (comprehensive metabolic panel which includes LFT's) yearly. However, the physician response did not include a rationale for not ordering a lipid panel. The Drug Regimen Review Report dated 9/29/17, included: Please define how often lipids should be monitored for patient on pravachol (pravastatin). When interviewed on 10/5/17, at 9:27 a.m. registered nurse (RN)-A confirmed R50's last lipid panel was completed on 6/16/15. RN-A further confirmed the physician did not respond to the pharmacy recommendation dated 6/26/17, related to (r/t) a yearly lipid panel nor gave rationale as to why a lipid panel was not ordered. RN-A also confirmed the most recent pharmacy recommendation dated 9/29/17, was faxed to the physician on 10/4/17 with no communication yet from the physician. When interviewed on 10/5/17 at 11:02 a.m. the director of nursing confirmed R50's medical record did not include documentation to support the rationale for not ordering a lipid panel to monitor the effectiveness of pravastatin. Document review of the diagnoses list dated 10/3/17, for R62 identified: cervical spine (C-2) fracture, atrial fibrillation, hyperlidemia and	F 428	continued review. All current pharmacy recommendations were evaluated and those without appropriate responses were returned to the physician for further comment and included additional information as needed. All September reports have been returned to the facility and have been addressed. Professional nursing staff were inserviced on 10/12/2017 or individually on a one on one basis, on the need to monitor any pharmacy recommendation returned from the physician for new orders and provide any additional information requested by the physician in a timely manner. The Director of Nursing or her designee will audit all future pharmacy recommendation sheets to insure they are returned, addressed by the physician in a timely manner, and contain complete responses. All audit results will be reported at the monthly QAPI meeting for review and decisions on further action needed, if necessary. Completion date 10/26/2017	

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F 428	Continued From page 17	F 428		

hypertension.

Review of the document titled Physician orders dated 10/4/17, the following was noted for R62: Aspirin 81 milligrams (mg) daily for atrial fibrillation, Coumadin 1.5 mg daily, and Lisinopril 10 mg daily.

The document titled, Pharmacy Review dated 6/27/17, and 7/31/17, revealed: recommend checking potassium (K+) level with use of Lisinopril and re-evaluate the need for Aspirin and Coumadin for atrial fibrillation, document need for both or consider d/c (discontinue), consider d/c for Aspirin.

The physician's only response dated 7/6/17, indicated "please continue". The physician's response lacked a rationale addressing the concurrent use of Aspirin and Coumadin.

Document review lacked completion of the recommended potassium level related to ongoing administration of Lisinopril.

When interviewed on 10/4/17, at 11:04 a.m. nurse manager (NM)-A confirmed the labwork had not been completed for R62 per pharmacy recommendation. Review of the medical record also lacked evidence that lab tests to evaluate the potassium level had been completed for R62.

When interviewed on 10/5/17, at 9:27 a.m. the director of nursing (DON) confirmed the physician did not respond to the pharmacy recommendation dated 6/27/17, related to the ongoing use of Aspirin and Coumadin nor the 7/31/17, recommendation for checking a potassium level in the blood related to the

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F 428	Continued From page 18 continued administration of the Lisinopril. Upon interview with the consulting pharmacist on 10/5/17, at 10:39 a.m. it was learned it would be the expectation for the physician to address the need for the potassium lab work especially with the ongoing order for Lisinopril, which can cause hyperkalemia (high level of potassium), a dangerous side effect.	F 428		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		10/26/17

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F 431	Continued From page 19 (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system was developed and implemented to reconcile as needed (PRN) narcotic medications for 4 of 4 residents (R36, R9, R18, R11) reviewed who had blister pack medications stored in 2 of 2 medication carts. Findings include: When the medication cart used for halls 1 and 2 was reviewed it was noted that R36 had a blister pack of tramadol (narcotic) for PRN (as needed)	F 431	F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The PRN Tramadol for Residents #36, #9, and #11 have been transferred to the locked narcotic box and are being counted on a shift by shift basis by the appropriate staff. All PRN medications were reviewed to determine if there were other Schedule IV meds that required monitoring and reconciling. Professional nursing staff were inserviced on 10/12/2017 or individually on a one on one basis on the need to make sure all PRN	

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F 431	Continued From page 20 use. The dispensation date was June 2017. There were 13 of the 16 doses dispensed from the blister pack. In addition, another full blister pack of tramadol was available for R36. Licensed practical nurse (LPN)-A who was present during the observation, indicated that periodic reconciliation of this PRN narcotic pain medication was not conducted by staff to identify potential diversion of this Schedule IV controlled drug. When questioned, LPN-A could not identify when the blister pack had arrived (dispensed) nor the times/dates R36 received the narcotic medication from the blister pack. It was also noted that R18 had a blister pack of hydrocodone medication (narcotic). It was noted that one of the tablets had been taped back into the packaging. LPN-A stated that staff often tape the back of the blister pack when they have been unable to administer the medication to the resident and/or if the medication has accidently been popped from the blister pack, but hadn't "gone anywhere near the resident". Review of the medication carts used for halls 3 and 4 identified that R9 and R11 also had PRN tramadol narcotic pain medication that had not been routinely reconciled. R11 had 8 doses dispensed of the 16 total tablets located in the blister pack dated 8/1/17. R9 had 10 doses remaining of the 30 tablets of tramadol that were dispensed to the facility on 4/28/17. There was no system for staff to reconcile the PRN doses administered to R9 and R11. Review of the facility's September 2016 Acquisition, Receiving, Dispensing, and Storage of Medications policy indicated Controlled drugs and other drugs subject to possible abuse will be	F 431	Schedule IV medications are reconciled at least daily. Nurses were instructed on the proper procedure if the foil on the back of the cassette becomes torn or compromised. If this occurs, the medication needs to be destroyed and recorded properly using two witnesses. Any medication that has been dispensed and consequently refused by a resident must also be destroyed and recorded according to procedure. Routine audits of cassettes in the medication cart will be conducted 2-3 times per month by the Director of Nursing or her designee for 3 months and then randomly thereafter. All audit results will be reported at the monthly QAPI meeting for review and decisions on further action needed, if necessary. Completion date 10/26/2017	

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F 431	Continued From page 21 reconciled at least daily through an appropriate systems of record receipt and disposition. All medications are packaged according to State pharmacy rules and labeled according to State pharmacy regulations. New labels will be applied as needed. There was no mention of cleanliness or maintaining the integrity of the medication room or medication packs.	F 431		

Electronically delivered
October 20, 2017

Mr. Timothy Swoboda, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

Re: Nursing Home Licensing Orders - Project Number S5549029

Dear Mr. Swoboda:

The above facility was surveyed on October 2, 2017 through October 5, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie at (507) 476-4233 or kathryn.serie@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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification Filecc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 10/2/17 - 10/5/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide proper toenail services for 1 of 1 resident (R29) reviewed who required staff assistance with foot care. Findings include: During observation and interview with an interpreter on 10/3/17, at 10:31 a.m. R29 complained of foot pain. R29 stated her son used to trim her toenails, but he had not done so in a long time. R29 indicated she had asked nursing staff to trim her toenails; however, no one had trimmed them. It was noted she had long, thick	2 830	Corrected	10/26/17

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2 830	Continued From page 3	2 830		

and yellow colored toenails. R29's right great toenail was jagged in appearance and she winced upon movement of her feet.

Review of R29's record indicated the following diagnoses: polyneuropathy (disease affecting nerve sensation in limbs), hemiplegia (paralysis on one side of the body), epilepsy, stroke and Type 2 diabetes. R29 received aspirin (ASA) therapy related to her history of stroke which increased her likelihood of bleeding. It was noted that R29 was not currently being pharmacologically treated for diabetes. R29's current care plan indicated she required 1 staff assistance with personal hygiene and bathing care. R29 required total assistance for activities of daily living, such as dressing, transfer and toilet use. The care plan lacked any reference to the diabetes diagnosis of diabetes nor any necessary bleeding precautions related to aspirin therapy.

Interview on 10/3/17, at 4:00 p.m. with licensed practical nurse (LPN)-A indicated she had been employed at the facility for 13 years. LPN-A stated R29 received nail care during bath time on Wednesday evenings from the nursing assistants (NA's). LPN-A stated being unaware R29 had a diabetes diagnosis.

When interviewed on 10/3/17, at 4:15 p.m. the director of nursing (DON) indicated she was made aware of R29's desire for podiatry services by the interpreter and the registered nurse (RN) coordinator. The DON also confirmed being unaware of the diabetic diagnosis. The DON stated it was the expectation that licensed nursing staff were to trim R29's toenails especially with a diabetic diagnosis. The DON confirmed she was unaware that staff weren't trimming R29's toenails as needed.

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2 830	Continued From page 4 Review of the February 2013 Care Plan policy indicated residents were to receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Review of the September 2012 Podiatric Care policy indicated residents were to receive treatment by qualified persons for foot disorders as well as skin and nail conditions of the feet. In addition, preventative care was to be given to avoid foot problems in diabetic residents and in residents with circulatory problems. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for contractures to assure they are receiving the necessary treatment/services to prevent worsening or development. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for contracture development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21045	Mn Rule 4658.0620 Subp. 4 Frequency of Meals; Dining Room Subp. 4. Dining room. Meals are to be served in a specified dining area consistent with the resident's choice and plan of care. This MN Requirement is not met as evidenced by:	21045		10/26/17

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21045	Continued From page 5 Based on observation, interview, and document review, the facility failed to respect resident choice of meal times for 1 of 1 dependent resident (R19) observed who was assisted after all the residents finished their meals. Findings include: Review of R19's medical record identified diagnoses include: dementia, weakness and a history of weight loss. R19 required total staff assistance with transfer to the dining room and required extensive assistance with eating. R19 was non-verbal but occasionally made yes or no comments. R19 was observed on 10/2/17, from 3:40 p.m. to 4:34 p.m. asleep in the Geri-chair (high back wheelchair) in the lounge area located in front of the nurse's station. R19 was again noted at that same location, in the same seated position at 5:30 p.m., 6:00 p.m. and 6:22 p.m. At 6:27 p.m., R19 was finally assisted to the dining room by staff for the supper meal. At 7:30 p.m., R19 was observed reaching for her full tray of food, unable to feed herself, totally dependent upon staff for food. Staff then began to assist with feeding R19. On 10/3/17, at 5:23 p.m. an unidentified staff member asked NA-A over her walkie-talkie "Can I bring room [R19] down to eat?" NA-A replied "Don't bring [R19]." Another staff member also requested to transport another resident to the dining room but NA-A did not respond. When interviewed on 10/3/17, at 5:48 p.m. licensed practical nurse (LPN)-B indicated that during meal time, 2 NA's are assigned to assist residents located in their rooms and 2 staff are assigned to assist resident's located in the dining	21045	Corrected	

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21045	Continued From page 6	21045		

room. It was observed that R19 had not yet been brought down to the meal yet at this time, 5:48 p.m. LPN-B agreed that waiting to bring resident's to the dining room who cannot express their desire/choice is based solely on staff convenience. LPN-B also agreed that dependent resident were not offered a meal time based on loss of appetite, weight loss or previous lifestyle. LPN-B indicated the evening meal had less available staff than during a day shift meal.

On 10/3/17, at 5:56 p.m. and 6:09 p.m. R19 had not yet been brought into the dining room for the meal. At 6:16 p.m. NA-B left the area to transport R19 to the dining room. Dietary staff were clearing plates in the dining room at this time. No other resident's were eating their meal at this time. R19 was assisted with the meal without any other resident's in the area.

When interviewed on 10/3/17, 6:25 p.m. NA-A explained that over the past few months four residents have required more assistance and required total assistance; adding, additional staff would be helpful. NA-A explained she advised staff not to bring R19 down as they were unable to assist with eating. NA-A explained they only assist one table with dependent resident's at a time; consequently, staff was instructed not to transport residents into the dining room.

Interview on 10/4/17 at 10:34 a.m. FM-B (R19) indicated she would often visit on Sundays, but also during the week. FM-B explained that R19 had declined in eating ability in the past four or so months and now required total assistance. FM-B stated she used to take R19 to supper at 5:00 p.m. but stopped as her food would sit in front of her and get cold, waiting for staff assistance. FM-B stated she would wait until 5:20 p.m. so

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staff would be available at that time. FM-B indicated she was unaware that R19 had been assisted at the end of the meal (6:30 p.m.) FM-B indicated R19's usual routine eating times were 7:00 a.m., noon and 5:00 p.m. ever since she could recall.

When interviewed on 10/5/17, at 1:49 p.m. the director of nursing (DON) indicated, "There are times when we have had to shift staff to accommodate a need, for instance call lights." The DON explained the facility was conducting a feeding assistance QA [quality assurance] based on a verbal complaint related to an arthritis resident. The DON indicated the resident was upset because staff left to assist another resident with eating. As a result, it was decided to bring residents to the dining room in shifts instead of adding extra staff. This was initiated on May, 23, 2017 and "we haven't done anything with it yet." The DON agreed it was the non-verbal dependent residents who were transported later into the dining room. When questioned how non-verbal residents were given the choice to come later to dining, the DON stated "They haven't expressed it." The DON stated she felt anytime between 5:00 p.m. and 6:30 p.m. was acceptable to wait for a meal (open dining), regardless of choice.

The DON further indicated the four scheduled evening NA's take breaks at: 4:30 p.m., 5:00 p.m., 5:30 p.m. and 6 p.m. since they do not have access to the kitchen after the supper meal; therefore, staff start taking breaks 2 hours after the start of the shift. The DON agreed the times of the breaks accommodated staff convenience and not resident choice. The DON agreed the open dining had considered the choices of resident's able to verbalize but had not

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21045	Continued From page 8 considered the preferences of non-verbal residents, such as R19. Review of the the facility's September 2017 Resident Choice Dining policy indicated its purpose was to ensure resident choice in dining and meal times. In cases where the resident has dementia, or other barriers or challenges to providing information related to food preferences, document efforts to learn preferences (e.g. contact family or close friend.) SUGGESTED METHOD OF CORRECTION: The director of nursing could develop a system to ask families regarding choice of meal time and/or previous lifestyle and choice. A schedule could be developed based on resident' need and choice instead of staff convenience. A quality indicator could be developed to ensure the dining experience is based on choice. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21045		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any	21530		10/26/17

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21530	Continued From page 9 irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the physician responded to the recommendations of the pharmacist related to monitoring the effectiveness of a cholesterol lowering medication (pravastatin), to monitor for the side effects of an anti-hypertensive medication (Lisinopril) with checking the potassium blood level and to indicate rationale for concurrent use of Aspirin and Coumadin for 2 of 5 residents (R50, R62) reviewed for drug irregularities.	21530	Corrected	

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Findings include:

R50's signed physician orders dated 10/4/17, included a current order for pravastatin 20 milligrams (mg) by mouth one time daily for vasculopathy (any disorder of the blood vessels). The physician order for pravastatin included a start date of 4/25/17.

R50's care plan last revised 5/17/17, indicated: The resident has altered cardiovascular status related to CAD (coronary artery disease), A-fib (atrial fibrillation), and hyperlipidemia.

Review of R50's medical record did not include evidence a recent lipid panel had been completed to monitor the effectiveness of pravastatin. The most recent lipid panel located in the record was dated 6/16/15.

Review of the consulting pharmacist's Drug Regimen Review Report dated 6/26/17, included a recommendation for yearly lab draw for complete blood count (CBC), lipids and liver function tests (LFT's). The physician response indicated: Make sure he has CBC, CMP (comprehensive metabolic panel which includes LFT's) yearly. However, the physician response did not include a rationale for not ordering a lipid panel. The Drug Regimen Review Report dated 9/29/17, included: Please define how often lipids should be monitored for patient on pravachol (pravastatin).

When interviewed on 10/5/17, at 9:27 a.m. registered nurse (RN)-A confirmed R50's last lipid panel was completed on 6/16/15. RN-A further confirmed the physician did not respond to the pharmacy recommendation dated 6/26/17,

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related to (r/t) a yearly lipid panel nor gave rationale as to why a lipid panel was not ordered. RN-A also confirmed the most recent pharmacy recommendation dated 9/29/17, was faxed to the physician on 10/4/17 with no communication yet from the physician.

When interviewed on 10/5/17 at 11:02 a.m. the director of nursing confirmed R50's medical record did not include documentation to support the rationale for not ordering a lipid panel to monitor the effectiveness of pravastatin.

Document review of the diagnoses list dated 10/3/17, for R62 identified: cervical spine (C-2) fracture, atrial fibrillation, hyperlidemia and hypertension.

Review of the document titled Physician orders dated 10/4/17, the following was noted for R62: Aspirin 81 milligrams (mg) daily for atrial fibrillation, Coumadin 1.5 mg daily, and Lisinopril 10 mg daily.

The document titled, Pharmacy Review dated 6/27/17, and 7/31/17, revealed: recommend checking potassium (K+) level with use of Lisinopril and re-evaluate the need for Aspirin and Coumadin for atrial fibrillation, document need for both or consider d/c (discontinue), consider d/c for Aspirin.

The physician's only response dated 7/6/17, indicated "please continue". The physician's response lacked a rationale addressing the concurrent use of Aspirin and Coumadin.

Document review lacked completion of the recommended potassium level related to ongoing administration of Lisinopril.

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21530	Continued From page 12 When interviewed on 10/4/17, at 11:04 a.m. nurse manager (NM)-A confirmed the labwork had not been completed for R62 per pharmacy recommendation. Review of the medical record also lacked evidence that lab tests to evaluate the potassium level had been completed for R62. When interviewed on 10/5/17, at 9:27 a.m. the director of nursing (DON) confirmed the physician did not respond to the pharmacy recommendation dated 6/27/17, related to the ongoing use of Aspirin and Coumadin nor the 7/31/17, recommendation for checking a potassium level in the blood related to the continued administration of the Lisinopril. Upon interview with the consulting pharmacist on 10/5/17, at 10:39 a.m. it was learned it would be the expectation for the physician to address the need for the potassium lab work especially with the ongoing order for Lisinopril, which can cause hyperkalemia (high level of potassium), a dangerous side effect. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		

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21540	Continued From page 13	21540		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to monitor the effectiveness of a cholesterol lowering medication (pravastatin), failed to monitor for the side effects of an anti-hypertensive medication (Lisinopril) and failed to provide adequate indications for concurrent use of aspirin and Coumadin for 2 of 5 residents (R50, R62) reviewed for unnecessary medications. Findings include:	21540	Corrected	10/26/17

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R50's signed physician orders dated 10/4/17, included a current order for pravastatin 20 milligrams (mg) by mouth one time daily for vasculopathy (any disorder of the blood vessels). The physician order for pravastatin included a start date of 4/25/17.

R50's care plan last revised 5/17/17, indicated: The resident has altered cardiovascular status related to CAD (coronary artery disease), A-fib (atrial fibrillation), and hyperlipidemia (high level of lipids in blood).

Review of R50's medical record did not include evidence a recent lipid panel had been completed to monitor the effectiveness of pravastatin, (treats high cholesterol and triglyceride levels). The most recent lipid panel located in the record was dated 6/16/15.

Review of the consulting pharmacist's Drug Regimen Review Report dated 6/26/17, included a recommendation for yearly lab draw for complete blood count (CBC), lipids and liver function tests (LFT's). The physician response indicated: Make sure he has CBC, CMP (comprehensive metabolic panel which includes LFT's) yearly. However, the physician response did not include a rationale for not ordering a lipid panel. The Drug Regimen Review Report dated 9/29/17, included: Please define how often lipids should be monitored for patient on pravachol (pravastatin).

When interviewed on 10/5/17, at 9:27 a.m. registered nurse (RN)-A confirmed R50's last lipid panel was completed on 6/16/15. RN-A further confirmed the physician did not respond to the pharmacy recommendation dated 6/26/17,

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21540	Continued From page 15	21540		

related to (r/t) a yearly lipid panel nor gave rationale as to why a lipid panel was not ordered.

When interviewed on 10/5/17 at 11:02 a.m. the director of nursing confirmed R50's medical record did not include documentation to support the rationale for not ordering a lipid panel to monitor the effectiveness of pravastatin.

Document review of the diagnoses list dated 10/3/17, for R62 identified: cervical spine (C-2) fracture, atrial fibrillation, hyperlidemia and hypertension.

Review of the document titled Physician orders dated 10/4/17, the following was noted for R62: Aspirin 81 mg daily for atrial fibrillation; Coumadin 1.5 mg daily; and Lisinopril 10 mg daily.

The document titled, Pharmacy Review dated 6/27/17, and 7/31/17, revealed: recommend checking potassium (K+) level with use of Lisinopril and re-evaluate the need for Aspirin and Coumadin for atrial fibrillation, document need for both or consider d/c (discontinue), consider d/c for aspirin.

The physician's only response dated 7/6/17, indicated "please continue". The physician's response lacked a rationale addressing the concurrent use of Aspirin and Coumadin.

Document review lacked completion of the recommended potassium level to monitor for a high potassium level related to ongoing administration of Lisinopril.

When interviewed on 10/4/17, at 11:04 a.m. nurse manager (NM)-A confirmed the lab (K+ level) had not been completed for R62 per pharmacy

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	00755	A. BUILDING: _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAK	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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) COMPLETE DATE
21540	Continued From page 16 recommendation to monitor for side effects. In addition, review of the medical record also lacked evidence the potassium level had been monitored. When interviewed on 10/5/17, at 9:27 a.m. the director of nursing (DON) confirmed the potassium level had not been monitored while R62 had been on Lisinopril. The DON confirmed that R62 had concurrent administration of Aspirin and Coumadin without adequate indications for use especially since the physician had not responded with the rationale for continuing both medications. Upon interview with the consulting pharmacist on 10/5/17 at 10:39 a.m. it was learned it is important to monitor the potassium level with the ongoing order for Lisinopril, which can cause hyperkalemia (high level of potassium), a dangerous side effect. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medications. Nursing staff could be educated as necessary to the importance of assement and monitoring. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21540		
21635	MN Rule 4658.1350 Subp. 3 Disposition of Medications; Loss or spillage Subp. 3. Loss or spillage. When a loss or	21635		10/26/17

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	00755	A. BUILDING: _____ B. WING _____	10/05/2017

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21635	Continued From page 17 spillage of a prescribed Schedule II drug occurs, an explanatory notation must be made in a Schedule II record. The notation must be signed by the person responsible for the loss or spillage and by one witness who must also observe the destruction of any remaining contaminated drug by flushing into the sewer system or wiping up the spill. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system was developed and implemented to reconcile as needed (PRN) narcotic medications for 4 of 4 residents (R36, R9, R18, R11) reviewed who had blister pack medications stored in 2 of 2 medication carts. Findings include: When the medication cart used for halls 1 and 2 was reviewed it was noted that R36 had a blister pack of tramadol (narcotic) for PRN (as needed) use. The dispensation date was June 2017. There were 13 of the 16 doses dispensed from the blister pack. In addition, another full blister pack of tramadol was available for R36. Licensed practical nurse (LPN)-A who was present during the observation, indicated that periodic reconciliation of this PRN narcotic pain medication was not conducted by staff to identify potential diversion of this Schedule IV controlled drug. When questioned, LPN-A could not identify when the blister pack had arrived (dispensed) nor the times/dates R36 received the narcotic medication from the blister pack. It was also noted that R18 had a blister pack of hydrocodone medication (narcotic). It was noted	21635	Corrected	

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21635	Continued From page 18	21635		

that one of the tablets had been taped back into the packaging. LPN-A stated that staff often tape the back of the blister pack when they have been unable to administer the medication to the resident and/or if the medication has accidently been popped from the blister pack, but hadn't "gone anywhere near the resident".

Review of the medication carts used for halls 3 and 4 identified that R9 and R11 also had PRN tramadol narcotic pain medication that had not been routinely reconciled. R11 had 8 doses dispensed of the 16 total tablets located in the blister pack dated 8/1/17. R9 had 10 doses remaining of the 30 tablets of tramadol that were dispensed to the facility on 4/28/17. There was no system for staff to reconcile the PRN doses administered to R9 and R11.

Review of the facility's September 2016 Acquisition, Receiving, Dispensing, and Storage of Medications policy indicated Controlled drugs and other drugs subject to possible abuse will be reconciled at least daily through an appropriate systems of record receipt and disposition. All medications are packaged according to State pharmacy rules and labeled according to State pharmacy regulations. New labels will be applied as needed. There was no mention of cleanliness or maintaining the integrity of the medication room or medication packs.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage, and labeling of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee,

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21635	Continued From page 19 along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/04/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	**745 BASINGER MEMORIAL DRIVE** **MOUNTAIN LAKE, MN 56159**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Building 01 of Good Samaritan Society Mountain Lake was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2017

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

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	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/04/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	**745 BASINGER MEMORIAL DRIVE** **MOUNTAIN LAKE, MN 56159**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Good Samaritan Society Mountain Lake was constructed as follows: The original building was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 2000 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The 2013 link addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. There are no resident sleeping or treatment areas located in this addition. This addition is separated from an assisted living facility by a proper two-hour fire wall assembly.	K 000		

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	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/04/2017**

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K 000	Continued From page 2 These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133 SS=E	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to maintain a 2-hour separation is provided in accordance with 8.2.1.3. The deficient practice	K 133	K133 MULTIPLE OCCUPANCIES The penetration between the nursing home and the AL building was resealed	10/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/04/2017**

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K 133	Continued From page 3 could affect 52 out of 49 residents. Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 10/04/2017, observation revealed a penetration around cables above the ceiling at the 2 hour fire separation connecting the Assisted Living Building. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 133	with fire caulking. Fire separations were all checked for compliance and will be inspected and audited monthly by the Maintenance Director or his designee. Any concerns or issues will be reported at the monthly QAPI committee meeting for review and decisions on further action if necessary. Completion Date 10/23/2017	