DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID:	P/JT	
Fac	Htv ID: 00755	

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MEDICARE/MEDICAID PROVID NO.(L1) 245549	DER	3. NAME AND AL (L3) GOOD SAM			OUNTAIN LAKE	4. TYPE OF ACTIO	ON: 7(L8) 2. Recertification
2. STATE VENDOR OR MEDICAID	NO	(L4) 745 BASIN (GER MEMOR	RIAL DRIV	E	3. Termination	4. CHOW
(L2) 477840500	7110.	(L5) MOUNTAIN	LAKE, MN		(L6) 56159	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEO	GORY	<u>02</u> (L7)	8. Full Survey Afte	r Complaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	o. Full Survey Afte	r Compianii
6. DATE OF SURVEY 11/3	3/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDI	ING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		ING DATE. (L33)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	ince With		And/Or Approved Waivers Of	The Following Requirem	ents:
To (b):		Program Re	equirements		2. Technical Personnel	_ 6. Scope of S	ervices Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical D	irector
12.Total Facility Beds	55 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Roc	om Size
13.Total Certified Beds	55 (L17)	D. Natin Cana	1:		5. Life Safety Code	9. Beds/Room	1
13. Total Certified Beds	CC (E17)	B. Not in Comp Requirements	and/or Applied		* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
55							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Kathryn Serie, Unit S	upervisor	1	1/30/2017	(L19)	Kamala Fiske-Downing, E	Enforcement Specia	alist 11/30/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBII			IPLIANCE WIT HTS ACT:	H CIVIL		ol Interest Disclosure Stmt	
1. Facility is Eligible to	-				3. Both of the Above	2:	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEI	MENT	26. TERMINATION ACTION:	:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	INVOLU	NTARY_
02/01/1991					01-Merger, Closure	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		er Status Change
	•		(L44)			00-Active	
(L27)	B. Rescind St	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00140					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	
	-	-	-		·	•	



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

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



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

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

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 PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	Ρ/.	JΤ	
Faci	litv	ID:	00755

MEDICARE/MEDICAID PROVID	DER	3. NAME AND AI				4. TYPE OF ACTI	ON: <u>2</u> (L8)
NO.(L1) 245549					OUNTAIN LAKE	1. Initial	2. Recertification
2. STATE VENDOR OR MEDICAIL (L2) 477840500	O NO.	(L4) 745 BASING (L5) MOUNTAIN		IAL DRIV	(L6) 56159	3. Termination 5. Validation 7. On-Site Visit	4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey Aft	
(L9)	0=/ 0 04=	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA		
	05/2017 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	ING DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPICE	09/30	
2 AOA 3 Other		045111	00 01 1/31	12 KHC	10 HOSI ICE	03,00	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	f The Following Requiren	nents:
To (b):		_	equirements e Based On:		2. Technical Personne	el 6. Scope of S	Services Limit
		_			3. 24 Hour RN	7. Medical D	
12.Total Facility Beds	55 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural S	<u> </u>	
13.Total Certified Beds	55 (L17)	X B. Not in Con	npliance with Pro	gram	5. Life Safety Code	9. Beds/Roor	m
		Requirements	and/or Applied	Waivers:	* Code: B*	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
55							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL	Date:
Jennifer Bahr, HFE N	NE II	1	0/30/2017	(L19)	Kamala Fiske-Downing,	Enforcement Speci	<u>falist</u> 11/13/2017 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE	STATE AGENCY	
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WITI	H CIVIL		ancial Solvency (HCFA-25	
1. Facility is Eligible to	Participate	RIGH	HTS ACT:		3. Both of the Abov	rol Interest Disclosure Stm ve:	ii (HCFA-1515)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	N:	(L30)
OF PARTICIPATION	BEGINNING	B DATE	ENDING DA	TE	VOLUNTARY 0	<u>INVOLU</u>	INTARY
02/01/1991					01-Merger, Closure	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-F10VI	der Status Change
(L27)			(L44)			00-Activ	e
(221)	B. Rescind St	aspension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00140					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	DATE			
	(L32)			(L33)	DETERMINATION APP	DDOMAI	



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRINTED: 10/30/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE COMF	SURVEY PLETED
		245549	B. WING _		10/0	5/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	survey was comple	rs and 5th, 2017, a standard ted at your facility by the nent of Health to determine if	F 00	0		
	your facility was in of 42 CFR Part 483 Requirements for L The facility's plan of as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electronic	compliance with requirements a, Subpart B, and ong Term Care Facilities. If correction (POC) will serve of compliance upon the otance. Because you are our signature is not required of first page of the CMS-2567 ic submission of the POC will				
	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with	F 24	2		10/26/17
	schedules (includin health care and pro consistent with his	nas a right to choose activities, g sleeping and waking times), viders of health care services or her interests, assessments, d other applicable provisions				
		nas a right to make choices s or her life in the facility that e resident.				
	members of the cor	nas a right to interact with mmunity and participate in s both inside and outside the				
_ABORATOR\	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

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

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
		245549	B. WING		10/	05/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIET	Y - MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 242	by: Based on observareview, the facility choice of meal time resident (R19) obsall the residents fir Findings include: Review of R19's mediagnoses include history of weight to assistance with trarequired extensive was non-verbal bucomments. R19 was observed 4:34 p.m. asleep in wheelchair) in the the nurse's station same location, in to 5:30 p.m., 6:00 p.m. R19 was finally as staff for the supper observed reaching to feed herself, tot food. Staff then be on 10/3/17, at 5:2 member asked NA bring room [R19] or "Don't bring [R19]. requested to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed reaching to feed herself, tot food. Staff then be on 10/3/17, at 5:2 member asked NA bring room [R19] or "Don't bring [R19]. The properties of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to trans dining room but National Part of the supper observed to th	age 1 ENT is not met as evidenced ation, interview, and document failed to respect resident es for 1 of 1 dependent served who was assisted afternished their meals. The dical record identified to dementia, weakness and a loss. R19 required total staff ansfer to the dining room and eleasistance with eating. R19 at occasionally made yes or no at the Geri-chair (high back lounge area located in front of R19 was again noted at that the same seated position at m. and 6:22 p.m. At 6:27 p.m., sisted to the dining room by remeal. At 7:30 p.m., R19 was a for her full tray of food, unable ally dependent upon staff for any of the same with feeding R19. The same and the staff area over her walkie-talkie "Can I down to eat?" NA-A replied "Another staff member also port another resident to the A-A did not respond.	F 24:	F242 SELF DETERMINATO MAKE CHOICES Due to her dementia, Resiable to make her own chodiscussed resident with hedetermined resident needs meals, based on daughter other residents who are nexpress their own desires in meal assistance have band we have contacted the well. Nursing staff were einservice of the profession 10/12/2017, a nursing asson 10/17/2017, and one or conversations or individual delivered to those who conthese meetings prior to 10 need to be aware of resided dignity at all times. A mee Performance Improvement team including nursing asson to complete a Root Cause these issues. Initial recomfrom this analysis have be Ongoing audits of 2-3 means the next month and then on week for an additional more conducted by the Director her designee for implement recommendations. Addition meetings will be held to ever effectiveness of initial recommendations and make changes as necessults will be reported at the contract of the c	ident #19 is not ices. Staff or daughter to se regarding of sinput. All obtable to about choices been identified eir family as ducated at an inal staff on instant inservice in one all memould not attend 0/26/2017 on the ent choices and eting of the ent project (PIP) sistants and eting of the ent choices and eting of the ent choices.	

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		245549	B. WING			10/0	05/2017
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE		74	REET ADDRESS, CITY, STATE, ZIP CODE 5 BASINGER MEMORIAL DRIVE OUNTAIN LAKE, MN 56159		
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F 242	during meal time, 2 residents located in assigned to assist a room. It was obser brought down to the p.m. LPN-B agreed to the dining room desire/choice is bacconvenience. LPN-resident were not closs of appetite, we LPN-B indicated the available staff than On 10/3/17, at 5:56 not yet been brough meal. At 6:16 p.m. R19 to the dining reclearing plates in the other resident's we time. R19 was assi other resident's in the When interviewed explained that over	nurse (LPN)-B indicated that R NA's are assigned to assist a their rooms and 2 staff are resident's located in the dining red that R19 had not yet been a meal yet at this time, 5:48. If that waiting to bring resident's who cannot express their sed solely on staff B also agreed that dependent affered a meal time based on eight loss or previous lifestyle, are evening meal had less during a day shift meal. So p.m. and 6:09 p.m. R19 had the into the dining room for the NA-B left the area to transport from. Dietary staff were are dining room at this time. No are eating their meal at this sted with the meal without any	F 2	42	QAPI meeting for review and decis further action if necessary will be meeting the committee. Completion date 10/26/2017		
	required total assis would be helpful. N staff not to bring R to assist with eating assist one table wit time; consequently transport residents Interview on 10/4/1 indicated she would	tance; adding, additional staff IA-A explained she advised 19 down as they were unable g. NA-A explained they only the dependent resident's at a graph at 10:34 a.m. FM-B (R19) doften visit on Sundays, but ek. FM-B explained that R19					

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
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F 242	months and now restated she used to p.m. but stopped a her and get cold, w FM-B stated she was assisted at the endindicated R19's us 7:00 a.m., noon an could recall. When interviewed director of nursing times when we have accommodate a new The DON explaine feeding assistance on a verbal complaresident. The DON upset because star with eating. As a residents to the diradding extra staff. 2017 and "we have The DON agreed in dependent resident into the dining room non-verbal resident come later to dinin haven't expressed anytime between 5 acceptable to wait regardless of choice.	equired total assistance. FM-B take R19 to supper at 5:00 s her food would sit in front of vaiting for staff assistance. Yould wait until 5:20 p.m. so lable at that time. FM-B unaware that R19 had been of the meal (6:30 p.m.) FM-B unaware that R19 had been of the meal (6:30 p.m.) FM-B unaware that R19 had been of the meal (6:30 p.m.) FM-B unaware that R19 had been of the meal (6:30 p.m.) FM-B unaware that R19 had been of the meal (6:30 p.m.) FM-B unaware that R19 had been of the meal (6:30 p.m.) FM-B unaware that R19 had been of the meal (6:30 p.m. the (DON) indicated, "There are the had to shift staff to end to shift staff to end for instance call lights." In the facility was conducting a part of the facility was the facility was the facility was the felt was the non-verbal the facility was the part of the facility was the felt was the part of the facility was conducting a part of the facility was the felt was the following the facility was the felt was the felt was the following the facility was the felt was the felt was the felt was for a meal (open dining),	F 24:			
	p.m., 5:30 p.m. and	d 6 p.m. since they do not have en after the supper meal:				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		X3) DATE SURVEY COMPLETED
		245549	B. WING		10/05/2017
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE	7	STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	
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	the start of the shift of the breaks according and not resident chopen dining had coresident's able to veconsidered the preferesidents, such as Review of the the faresident Choice Dipurpose was to ensure and meal times. In dementia, or other providing information document efforts to contact family or cloth 483.24(a)(2) ADL COEPENDENT RES (a)(2) A resident who activities of daily living services to maintain personal and oral horal than the facility from the	t taking breaks 2 hours after. The DON agreed the times immodated staff convenience oice. The DON agreed the insidered the choices of erbalize but had not derences of non-verbal results. September 2017 in ning policy indicated its sure resident choice in dining cases where the resident has barriers or challenges to on related to food preferences, a learn preferences (e.g. ose friend.) CARE PROVIDED FOR IDENTS The indicated is a preference of the indicated in t	F 242		any I I a C.N.P. This
		cated she had asked nursing		for the condition of their toenails and	

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	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	<i>,</i>	
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F 312	trimmed them. It wand yellow colored toenail was jagged upon movement of Review of R29's rediagnoses: polynenerve sensation in on one side of the Type 2 diabetes. Referance the likelist that R29 was not opharmacologically current care plan in assistance with pecare. R29 required of daily living, such use. The care plandiabetes diagnosis bleeding precaution. Interview on 10/3/1 practical nurse (LP employed at the fastated R29 receives Wednesday evening (NA's). LPN-A stated diabetes diagnosis. When interviewed director of nursing made aware of R2 by the interpreter accoordinator. The Eunaware of the diastated it was the extended to the state of the diastated it was the extended to the state of the diastated it was the extended to the state of R2 by the interpreter accoordinator. The Eunaware of the diastated it was the extended to the state of R2 by the interpreter accoordinator. The Eunaware of the diastated it was the extended to the state of R2 by the interpreter accoordinator. The Eunaware of the diastated it was the extended to the state of R2 by the interpreter accoordinator. The Eunaware of the diastated it was the extended to the state of R2 by the interpreter accoordinator. The Eunaware of the diastated it was the extended to the state of R2 by the interpreter accordinator.	enails; however, no one had as noted she had long, thick toenails. R29's right great in appearance and she winced ther feet. Cord indicated the following uropathy (disease affecting limbs), hemiplegia (paralysis body), epilepsy, stroke and 29 received aspirin (ASA) her history of stroke which hood of bleeding. It was noted urrently being treated for diabetes. R29's indicated she required 1 staff resonal hygiene and bathing ditotal assistance for activities as dressing, transfer and toilet lacked any reference to the of diabetes nor any necessary ins related to aspirin therapy. 7, at 4:00 p.m. with licensed the N)-A indicated she had been cility for 13 years. LPN-A and nail care during bath time on the nursing assistants the deep unaware R29 had a	F 3	need for immediate interventi were trimmed as needed and thickened nails are being refe pending resident or family appodiatrist. Nursing staff were an inservice of the profession 10/12/2017, a nursing assista on 10/17/2017, and also one conversations or individual m delivered to those who could these meetings prior to 10/26 Discussed was the need to trall residents at the time of the Those residents who are diable thickened and difficult are to himmediately to the charge nurplans were evaluated to insurapproaches for diabetic nail of present on the care plan and available to the nursing assist charge nurse, upon investigar resident's nails, does not feel to safely trim the nails then a be made to the either the phy podiatrist. Audits of 2-3 resid will be conducted by the Direct Nursing or her designee, ever 2 months and then randomly insure compliance. All audit reported at the monthly QAPI review and decisions on furth needed, if necessary. Comp 10/26/2017	those with arred, broval to the educated at al staff on int inservice on one emo not attend /2017. In toenails of ir shower. Detic or have be referred are were thus stants. If the she is able referral will sician or the ent toenails ctor of month for thereafter to esults will be meeting for er action	

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		245549	B. WING _		10/	05/2017
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312		ge 6 The DON confirmed she was veren't trimming R29's toenails	F 31	2		
	Review of the Februindicated residents provided the neces attain or maintain the	uary 2013 Care Plan policy were to receive and be sary care and services to ne highest practicable dance with the comprehensive				
F 328 SS=D	policy indicated res treatment by qualifi as well as skin and addition, preventati avoid foot problems residents with circu 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE	F 32	28		10/26/17
		ensure that residents receive nd care to maintain mobility h, the facility must:				
	with professional st	e and treatment, in accordance andards of practice, including itions from the resident's) and				
	appointments with a	sist the resident in making a qualified person, and portation to and from such				
	The facility must en	erostomy, or ileostomy care. sure that residents who ureterostomy, or ileostomy				

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F 328	services, receive professional stand comprehensive pothe resident's goal (g)(5) A resident verceives the approtonation of the receives the approton of the receives the approtonation of the receives the approtonation of the receives the resident which are sident which are sident who has and assistance, contained the receives the	such care consistent with dards of practice, the erson-centered care plan, and als and preferences. Who is fed by enteral means opriate treatment and services aplications of enteral feeding imited to aspiration pneumonia, if dehydration, metabolic dinasal-pharyngeal ulcers. Ids. Parenteral fluids must be sistent with professional tice and in accordance with the comprehensive care plan, and the resident's nees. The facility must ensure to needs respiratory care, stomy care and tracheal yided such care, consistent with dards of practice, the erson-centered care plan, the nd preferences, and 483.65 of the facility must ensure that a a prosthesis is provided care onsistent with professional tice, the comprehensive care plan, the residents' goals to wear and be able to use the	F3	F328 TREATMENT/CARE		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245549	B. WING			10/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7	45 BASINGER MEMORIAL DRIVE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		N	OUNTAIN LAKE, MN 56159		
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F 328	Continued From pa	age 8	F 3	28			
	review, the facility for proper foot care for reviewed who had diagnoses of diabeter Findings include: During observation interpreter on 10/3/	railed to offer and/or provide r 1 of 1 resident (R29) untrimmed toenails and had a tes and neuropathy. and interview with an railed and raile			SPECIAL NEEDS Resident #29 was seen immediatel her clinic to determine if there were issues with her toenails that require attention. No issues were noted ar recommendation was made by the to see the podiatrist at the next visit was accomplished on 10/18/2017. other residents who did not see the	ed any ed a control of the control o	
	to trim her toenails long time. R29 indi staff to trim her toe trimmed them. It w and yellow colored toenail was jagged upon movement of				podiatrist on 10/18/2017 were asset for the condition of their toenails an need for immediate intervention. Not were trimmed as needed and those thickened nails are being referred, pending resident or family approval podiatrist. Nursing staff were educan inservice of the professional star 10/12/2017, a nursing assistant ins	d any ails with to the ated at ff on ervice	
	diagnoses: polyne nerve sensation in on one side of the Type 2 diabetes. R therapy related to hincreased her likeli that R29 was not copharmacologically current care plan ir assistance with percare. R29 required of daily living, such use. The care plan diabetes diagnosis	cord indicated the following uropathy (disease affecting limbs), hemiplegia (paralysis body), epilepsy, stroke and 29 received aspirin (ASA) her history of stroke which hood of bleeding. It was noted urrently being treated for diabetes. R29's adicated she required 1 staff resonal hygiene and bathing at total assistance for activities as dressing, transfer and toilet lacked any reference to the of diabetes nor any necessary as related to aspirin therapy.			on 10/17/2017, and also one on on conversations or individual memo delivered to those who could not at these meetings prior to 10/26/2017 Discussed was the need to trim toe all residents at the time of their sho Those residents who are diabetic of thickened and difficult are to be referenced in the charge nurse. A plans were evaluated to insure approaches for diabetic nail care where the care plan and thus available to the nursing assistants. Charge nurse, upon investigation of resident's nails, does not feel she is to safely trim the nails then a reference	tend . enails of wer. or have erred All care ere If the s able al will	
	practical nurse (LP employed at the fa	7, at 4:00 p.m. with licensed N)-A indicated she had been cility for 13 years. LPN-A d nail care during bath time on			be made to the either the physician podiatrist. Audits of 2-3 resident to will be conducted by the Director of Nursing or her designee, every more 2 months and then randomly thereas	enails th for	

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		245549	B. WING		10/9	05/2017
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F 328	(NA's). LPN-A statt diabetes diagnosis physician's order for admission to the far When interviewed director of nursing made aware of R29 by the interpreter a coordinator. The Dunaware of the dial stated it was the existaff were to trim Findiabetic diagnosis. unaware that staff was needed. The DOunaware that staff was needed. The DOunaware that staff wand that Podiatry sistanding order for a facility. Review of the Febrindicated residents provided the necessattain or maintain the well-being in accordansessment. Review of the Septipolicy indicated residents provided the necessattain or maintain the well-being in accordansessment.	gs from the nursing assistants ed being unaware R29 had a . R29 received a standing or podiatry services upon her	F 328	insure compliance. All audit is reported at the monthly QAPI review and decisions on furth needed, if necessary. Complete 10/26/2017	meeting for er action	
F 329 SS=D	addition, preventati avoid foot problems residents with circu	ve care was to be given to s in diabetic residents and in latory problems. DRUG REGIMEN IS FREE	F 329			10/26/17

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245549	B. WING		10/	05/2017	
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	, ,,		
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F 329	Each resident's dru unnecessary drugs drug when used (1) In excessive do therapy); or (2) For excessive of (3) Without adequal (4) Without adequal (5) In the presence which indicate the discontinued; or (6) Any combination paragraphs (d)(1) the 483.45(e) Psychote Based on a compresident, the facility (1) Residents who drugs are not given medication is neces	esary Drugs-General. ag regimen must be free from b. An unnecessary drug is any see (including duplicate drug duration; or ate monitoring; or ate indications for its use; or a of adverse consequences dose should be reduced or ans of the reasons stated in through (5) of this section.	F 329				
	gradual dose reduc	use psychotropic drugs receive ctions, and behavioral ss clinically contraindicated, in inue these drugs;					

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245549	B. WING		10/	05/2017
NAME OF PROVIDE		Y - MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	, , , ,	
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This I by: Base facility chole failed anti-hy failed concurreside medical Finding vascumillig vascumil	ed on interviery failed to mosterol lowering to monitor for appertensive of the provide acurrent use of ents (R50, Recations. In the provide acurrent use of ents (R50, Recations. In the provide acurrent use of ents (R50, Recations. In the provide acurrent use of ents (R50, Recations. In the provide acurrent use of ents (R50, Recations. In the provide acurrent use of ents (R50, Recations). In the provide acurrent use of ents (R50's not ents (R50's not ents). In the provide acurrent use of R50's not ents (R50's not ents). In the provide acurrent use of R50's not ents (R50's not ents). In the provide acurrent use of R50's not ents (R50's not ents). In the provide acurrent use of ents (R50's not ents). In the	w and document review the point or the effectiveness of a ring medication (pravastatin), or the side effects of an imedication (Lisinopril) and dequate indications for aspirin and Coumadin for 2 of 5 (52) reviewed for unnecessary sician orders dated 10/4/17, order for pravastatin 20 or mouth one time daily for disorder of the blood vessels).	F 329	F329 DRUG REGIMEN IS FRE UNNECESSARY DRUGS The physician for Resident #50 of contacted and an order was obtained and an order was obtained for both Aspirin and Couma well as the need for the potassion drawn. The order for the potassion drawn. The order for the potassion obtained and was drawn on 10/2 The physician wrote his rationale continuing both the ASA and the Coumadin. A letter was sent to attending physicians, explaining to promptly review and return the pharmacy recommendations and provide a rationale for any decision it was explained to each physicia facility would do its best to provide sufficient documentation, along of pharmacy recommendations, for make an informed decision. The also informed the physicians that would return all recommendation that were not addressed adequate continued review. All current pharmacy recommendations were evaluated those without appropriate resported to the physician for furth comment and included additional information as needed. All Septing reports have been returned to the and have been addressed. Profession of the profession of the physician for furth comment and included additional information as needed. All Septing the physician for furth comment and included additional information as needed. All Septing the physician for furth comment and included additional information as needed. All Septing the physician for furth and have been addressed. Profession physician for furth and have been addressed. Profession physician for furth and have been addressed.	vas hined to yearly desident on on the hadin as m to be him was 5/2017. If for hall the need had also han that the he he them to he letter he with the he sheets help for harmacy had and hases were her he mber he facility	

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	(comprehensive m LFT's) yearly. How did not include a rapanel. The Drug R 9/29/17, included: should be monitore (pravastatin). When interviewed registered nurse (F panel was complete confirmed the physical pharmacy recommendated to (r/t) a yerationale as to why when interviewed director of nursing record did not inclute rationale for not monitor the effective Document reviewed 10/3/17, for R62 in fracture, atrial fibril hypertension. Review of the document title 6/27/17, and 7/31/checking potassiun Lisinopril and re-execument for atrial for atrial for atrial for atrial for atrial for a trial formation and the companion of the document title 6/27/17, and 7/31/checking potassiun Lisinopril and re-execument for atrial formation and the companion of the document for atrial formation of the document formation of the documen	age 12 are he has CBC, CMP detabolic panel which includes dever, the physician response ationale for not ordering a lipid degimen Review Report dated Please define how often lipids and for patient on pravachol on 10/5/17, at 9:27 a.m. RN)-A confirmed R50's last lipid ded on 6/16/15. RN-A further dician did not respond to the definedation dated 6/26/17, arly lipid panel nor gave or a lipid panel was not ordered. on 10/5/17 at 11:02 a.m. the confirmed R50's medical ded documentation to support of ordering a lipid panel to oveness of pravastatin. Of the diagnoses list dated dentified: cervical spine (C-2) dation, hyperlidemia and ument titled Physician orders following was noted for R62: or for atrial fibrillation; Coumadin Lisinopril 10 mg daily. dd, Pharmacy Review dated 17, revealed: recommend on (K+) level with use of ovaluate the need for Aspirin and all fibrillation, document need for ovaluate the need for Aspirin and all fibrillation, consider d/c (c (discontinue), consider d/c	F 329	pharmacy recommendation the physician for new orders any additional information re the physician in a timely man Director of Nursing or her de audit all future pharmacy reconstruction sheets to insure they are returned addressed by the physician manner, and contain complete All audit results will be report monthly QAPI meeting for reducisions on further action in necessary. Completion day	and provide equested by nner. The esignee will commendation urned, in a timely ete responses. ted at the eview and needed, if	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245549	B. WING_		10	/05/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP COD 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159			
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F 329	indicated "please or response lacked a concurrent use of A Document review la recommended pota high potassium leve administration of Li When interviewed of manager (NM)-A conot been completed recommendation to addition, review of the evidence the potassium level had potassium level had R62 had been on L that R62 had conculand Coumadin with use especially since	y response dated 7/6/17, ontinue". The physician's rationale addressing the aspirin and Coumadin. acked completion of the assium level to monitor for a sel related to ongoing	F 32	29			
	10/5/17 at 10:39 a.i important to monito ongoing order for L hyperkalemia (high dangerous side effe	DRUG REGIMEN REVIEW,	F 42	28		10/26/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245549	B. WING		10/05/2017	
	PROVIDER OR SUPPLIEF	Y - MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
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F 428	c) Drug Regimen (1) The drug regin reviewed at least opharmacist. (3) A psychotropic brain activities assand behavior. The limited to, drugs in (i) Anti-psychotic; (ii) Anti-depressar (iii) Anti-anxiety; a (iv) Hypnotic. (4) The pharmacist to the attending placility's medical dand these reports (i) Irregularities induring that meets the during that meets the during this review separate, written rattending physicial director and direct minimum, the resiand the irregularity (iii) The attending resident's medical irregularity has be action has been to the direct of the second to the second the irregularity has be action has been to the second to the second to the second	Review nen of each resident must be once a month by a licensed drug is any drug that affects esciated with mental processes ese drugs include, but are not a the following categories: at; at; at must report any irregularities	F 4	28		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245549	B. WING			10/05/2017	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE		74	REET ADDRESS, CITY, STATE, ZIP CODE 15 BASINGER MEMORIAL DRIVE OUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	the resident's medication (5) The facility must and procedures for review that include, frames for the diffesteps the pharmacidentifies an irregul to protect the residentifies an irregul to protect the residentifies an interview facility failed to ensithe recommendation monitoring the effects of a medication (Lisinor potassium blood leconcurrent use of Aresidents (R50, R6 irregularities. Findings include: R50's signed physical included a current of milligrams (mg) by vasculopathy (any of the physician ordes start date of 4/25/1 R50's care plan last The resident has a related to CAD (con (atrial fibrillation), and the control of the control o	t develop and maintain policies the monthly drug regimen but are not limited to, time rent steps in the process and st must take when he or she arity that requires urgent action ent. NT is not met as evidenced and document review the ure the physician responded to ons of the pharmacist related to ctiveness of a cholesterol in (pravastatin), to monitor for an anti-hypertensive oril) with checking the vel and to indicate rationale for aspirin and Coumadin for 2 of 5 (2) reviewed for drug cian orders dated 10/4/17, order for pravastatin 20 mouth one time daily for disorder of the blood vessels). In the process of the phonodous and the phonodous and the process of the phonodous and the process of the phonodous and t	F 4	128	F428 DRUG REGIMEN REVIEW, REPORT IRREGULAR The physician for Resident #50 was contacted and an order was obtained draw a Lipid Panel now and then yet thereafter. This was drawn on 10/16/2017. The physician for Resi #62 was contacted for clarification on need for both Aspirin and Coumadir well as the need for the potassium obtained and was drawn on 10/25/2 The physician wrote his rationale for continuing both the ASA and the Coumadin. A letter was sent to all attending physicians, explaining the to promptly review and return the pharmacy recommendations and all provide a rationale for any decision. It was explained to each physician to facility would do its best to provide sufficient documentation, along with pharmacy recommendations, for the make an informed decision. The lealso informed the physicians that we would return all recommendation should return all recommendation shou	ed to early ident on the n as to be n was 2017. r e need so made. that the em to tter e neets	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		03/2017	
		7 - MOUNTAIN LAKE		745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159			
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F 428	evidence a recent to monitor the effer most recent lipid p dated 6/16/15. Review of the consequence of the	lipid panel had been completed ctiveness of pravastatin. The anel located in the record was sulting pharmacist's Drug Report dated 6/26/17, included a for yearly lab draw for unt (CBC), lipids and liver r's). The physician response are he has CBC, CMP attabolic panel which includes vever, the physician response ationale for not ordering a lipid regimen Review Report dated Please define how often lipids red for patient on pravachol on 10/5/17, at 9:27 a.m. RN)-A confirmed R50's last lipid ted on 6/16/15. RN-A further sician did not respond to the nendation dated 6/26/17, arly lipid panel nor gave a lipid panel was not ordered. The defendation dated 9/29/17, was faxed to the lipid with no communication yet	F 42	continued review. All current recommendations were evaluated those without appropriate respective returned to the physician for comment and included addition information as needed. All Screports have been returned to and have been addressed. Poursing staff were inserviced 10/12/2017 or individually on basis, on the need to monitor pharmacy recommendation or the physician for new orders any additional information returned the physician in a timely man Director of Nursing or her deaudit all future pharmacy recommendation in a timely man Director of Nursing or her deaudit all future pharmacy recommendation in a timely man Director of Nursing or her deaudit all future pharmacy recommendation in manner, and contain completed All audit results will be report monthly QAPI meeting for redecisions on further action not necessary. Completion dates	pated and sponses were further onal eptember of the facility rofessional on a one on one any eturned from and provide quested by ner. The signee will ommendation irned, on a timely the responses, and eeded, if		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 428	hypertension. Review of the doc dated 10/4/17, the Aspirin 81 milligrar fibrillation, Couma 10 mg daily. The document title 6/27/17, and 7/31/checking potassiu Lisinopril and re-ec Coumadin for atria both or consider d for Aspirin. The physician's or indicated "please or response lacked a concurrent use of Document review recommended potadministration of L. When interviewed manager (NM)-A commendation, also lacked evider potassium level has when interviewed director of nursing did not respond to recommendation ongoing use of As 7/31/17, recommended.	ument titled Physician orders following was noted for R62: ms (mg) daily for atrial din 1.5 mg daily, and Lisinopril ed, Pharmacy Review dated 17, revealed: recommend m (K+) level with use of valuate the need for Aspirin and al fibrillation, document need for /c (discontinue), consider d/c ally response dated 7/6/17, continue". The physician's rationale addressing the Aspirin and Coumadin. lacked completion of the assium level related to ongoing isinopril. on 10/4/17, at 11:04 a.m. nurse confirmed the labwork had not for R62 per pharmacy Review of the medical record for R62 per pharmacy and been completed for R62. on 10/5/17, at 9:27 a.m. the (DON) confirmed the physician		8			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION IG		E SURVEY IPLETED
		245549	B. WING _		10/	05/2017
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F 431 SS=D	continued administ Upon interview with 10/5/17, at 10:39 at the expectation for need for the potass the ongoing order of hyperkalemia (high dangerous side effect 483.45(b)(2)(3)(g)(LABEL/STORE DRIVED The facility must prodrugs and biological them under an agres 483.70(g) of this punicensed personnel aw permits, but on supervision of a lice (a) Procedures. A pharmaceutical ser that assure the accedispensing, and ad biologicals) to mee (b) Service Consult employ or obtain the pharmacist who (2) Establishes a sydisposition of all codetail to enable an (3) Determines that that an account of a state of the control	ration of the Lisinopril. In the consulting pharmacist on it was learned it would be the physician to address the sium lab work especially with or Lisinopril, which can cause level of potassium), a sect. In) DRUG RECORDS, EUGS & BIOLOGICALS In ovide routine and emergency als to its residents, or obtain element described in part. The facility may permit all to administer drugs if State by under the general	F 42			10/26/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 431	останова тот ра	<u> </u>	F 43	1		
	labeled in accordar professional princip appropriate access	als used in the facility must be nce with currently accepted oles, and include the				
	the facility must sto locked compartme	with State and Federal laws, ore all drugs and biologicals in nts under proper temperature it only authorized personnel to				
	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distr quantity stored is not be readily detected. This REQUIREME	t provide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit libution systems in which the hinimal and a missing dose can. NT is not met as evidenced				
	review, the facility of developed and imposeded (PRN) nare residents (R36, R9 blister pack medication carts. Findings include: When the medication was reviewed it was	tion, interview, and document failed to ensure a system was elemented to reconcile as cotic medications for 4 of 4, R18, R11) reviewed who had ations stored in 2 of 2 on cart used for halls 1 and 2 is noted that R36 had a blister harcotic) for PRN (as needed)		F431 DRUG RECORDS, LABEL/S DRUGS & BIOLOGICALS The PRN Tramadol for Residents # and #11 have been transferred to to locked narcotic box and are being counted on a shift by shift basis by appropriate staff. All PRN medicat were reviewed to determine if there other Schedule IV meds that require monitoring and reconciling. Professing staff were inserviced on 10/12/2017 or individually on a one basis on the need to make sure all	#36, #9, ne the ions e were red sional on one	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159					
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F 431	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	131	Schedule IV medications are reconleast daily. Nurses were instructed proper procedure if the foil on the bithe cassette becomes torn or compromised. If this occurs, the medication needs to be destroyed a recorded properly using two witnes. Any medication that has been disperent and consequently refused by a resimust also be destroyed and record according to procedure. Routine a cassettes in the medication cart will conducted 2-3 times per month by Director of Nursing or her designed months and then randomly thereaft audit results will be reported at the monthly QAPI meeting for review a decisions on further action needed necessary. Completion date 10/2	and ses. ensed dent ed udits of I be the efor 3 er. All and if		
	Review of the facility Acquisition, Receive of Medications policity	ty's September 2016 ing, Dispensing, and Storage by indicated Controlled drugs bject to possible abuse will be						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 431	systems of record r medications are pa pharmacy rules and pharmacy regulation as needed. There we	daily through an appropriate receipt and disposition. All ckaged according to State d labeled according to State ns. New labels will be applied was no mention of cleanliness ntegrity of the medication	F 4	31				



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: 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

PRINTED: 10/30/2017 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00755		B. WING		10/	05/2017		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE ZIP CODE				
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	****ATTEN	NTION*****							
	NH LICENSING CORRECTION ORDER								
	144A.10, this correct pursuant to a surver found that the deficit herein are not corrected shall be a surver of corrected shall be a surver of the survey of	ected, a fine for each be assessed in acco ines promulgated by	i issued tion, it is cited i violation ordance						
	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.								
	that may result from orders provided that the Department with	hearing on any assen non-compliance wi t a written request is nin 15 days of receip nt for non-compliand	th these made to ot of a						
	receipt of State licer the Minnesota Depa Informational Bullet	participate in the ele nsure orders consist artment of Health in 14-01, available a state.mn.us/divs/fpc ate licensing orders	tent with t /profinfo/in						

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

Electronically Signed 10/27/17

TITLE

STATE FORM 6899 If continuation sheet 1 of 20 P7JT11

PRINTED: 10/30/2017 FORM APPROVED

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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Depayous is neente text. State commonre Minn On 1 Department of Pleas corre and Minn the State state "Sun and corre finding after evide are to Time PLE. FOU "PRO APP	electronically. Accessary for Star the word "corrected prior to elected pr	Although no plan of cate Statutes/Rules, planeted" in the box avaindicate in the electrocess, under the head e date your orders will ectronically submitting the following the above process of this visited the above process are issued our electronic plan of have reviewed these e when they will be concent of Health is document of	correction ease silable for onic ing ll be go to the ovider and d. for orders, completed. Immenting sing en es for e far left the olumn the des the e statute et as and of the limits of the left as and of the left as a le	2 000				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. MN Rule 4658.0520 Subp. 1 Adequate and					
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			10/26/17
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from to	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and any home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observatireview, the facility faservices for 1 of 1 r	on, interview, and document ailed to provide proper toenail esident (R29) reviewed who tance with foot care.		Corrected		
	Findings include:					
	interpreter on 10/3/ complained of foot to trim her toenails, long time. R29 indic staff to trim her toel	and interview with an 17, at 10:31 a.m. R29 pain. R29 stated her son used but he had not done so in a cated she had asked nursing nails; however, no one had as noted she had long, thick				

Minnesota Department of Health

STATE FORM P7JT11 If continuation sheet 3 of 20

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00755		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	- MOLINTAIN I Ak	745 BASI		TATE, ZIP CODE DRIAL DRIVE 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	and yellow colored toenail was jagged upon movement of Review of R29's rediagnoses: polyner nerve sensation in on one side of the type 2 diabetes. R2 therapy related to hincreased her likelif that R29 was not copharmacologically tourrent care plan in assistance with percare. R29 required of daily living, such use. The care plan diabetes diagnosis bleeding precaution. Interview on 10/3/1 practical nurse (LPI employed at the fact stated R29 received Wednesday evenin (NA's). LPN-A stated diabetes diagnosis. When interviewed of director of nursing (made aware of R29 by the interpreter arcoordinator. The Dunaware of the diabetes diagnosis.	toenails. R29's right gin appearance and she her feet. cord indicated the folkeropathy (disease affeimbs), hemiplegia (pactody), epilepsy, stroke 29 received aspirin (Aler history of stroke whood of bleeding. It warrently being reated for diabetes. Redicated she required sonal hygiene and bat total assistance for a as dressing, transfer lacked any reference of diabetes nor any not related to aspirin the R)-A indicated she had sility for 13 years. LPN dinail care during bath gs from the nursing as ged being unaware R29	e winced owing citing ralysis and SA) nich as noted 29's 1 staff thing ctivities and toilet to the ecessary erapy. ensed d been -A time on ssistants had a n. the vas services e (RN) eing DON	2 830			
	coordinator. The D unaware of the diab stated it was the ex staff were to trim R diabetic diagnosis.	ON also confirmed be petic diagnosis. The D	eing OON d nursing ly with a she was				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			SURVEY PLETED	
		00755		B. WING		10/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAF		NGER MEMO N LAKE, MN	DRIAL DRIVE I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4		2 830			
	indicated residents provided the necess attain or maintain th	uary 2013 Care Plan were to receive and sary care and service ne highest practicable dance with the comp	be es to e				
	policy indicated resi treatment by qualific as well as skin and addition, preventation	ember 2012 Podiatrice idents were to receive de persons for foot on all conditions of the ve care was to be given in diabetic residents latory problems.	re lisorders e feet. In ven to				
	The director of nurs all residents at risk they are receiving the treatment/services to development. The designee, could con- delivery of care; to e	to prevent worsening director of nursing o nduct random audits ensure appropriate o nented; to reduce the	ald review assure g or r of the care and				
	TIME PERIOD FOR (21) days.	R CORRECTION: TV	venty-one				
21045	Mn Rule 4658.0620 Dining Room	Subp. 4 Frequency	of Meals;	21045			10/26/17
		om. Meals are to be rea consistent with t nd plan of care.					
	This MN Requirements by:	ent is not met as evi	denced				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00755		B. WING		10/0	05/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAF	745 BASII		STATE, ZIP CODE DRIAL DRIVE I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21045	Continued From pa	ge 5		21045			
	review, the facility factorice of meal time	ion, interview, and do ailed to respect resides s for 1 of 1 depende erved who was assis ished their meals.	dent ent		Corrected		
	Findings include:						
	diagnoses include: history of weight los assistance with trar required extensive	edical record identifice dementia, weakness as. R19 required total ansfer to the dining role assistance with eating occasionally made y	s and a al staff om and ng. R19				
	4:34 p.m. asleep in wheelchair) in the lot the nurse's station. same location, in th 5:30 p.m., 6:00 p.m R19 was finally ass staff for the supper observed reaching to feed herself, total	on 10/2/17, from 3:4 the Geri-chair (high bunge area located i R19 was again note as ame seated position and 6:22 p.m. At 6 isted to the dining romeal. At 7:30 p.m., for her full tray of for legan to assist with feet the grant of the sisted to assist with feet the grant of the sisted to assist with feet the control of the sisted to assist with feet the control of the sisted to assist with feet the control of the control of the sisted the control of the	back in front of ed at that tion at 5:27 p.m., bom by R19 was od, unable staff for				
	member asked NA- bring room [R19] do "Don't bring [R19]."	p.m. an unidentified -A over her walkie-ta own to eat?" NA-A re Another staff memb oort another resident -A did not respond.	ilkie "Can I eplied er also				
	licensed practical n during meal time, 2 residents located in	on 10/3/17, at 5:48 p urse (LPN)-B indicat NA's are assigned to their rooms and 2 s resident's located in	ted that to assist staff are				

Minnesota Department of Health

STATE FORM P7JT11 If continuation sheet 6 of 20

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00755	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AF	NGER MEMO N LAKE, MN	DRIAL DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21045	brought down to the p.m. LPN-B agreed to the dining room of desire/choice is base convenience. LPN-resident were not oloss of appetite, we LPN-B indicated the available staff than On 10/3/17, at 5:56 not yet been brough meal. At 6:16 p.m. R19 to the dining reclearing plates in the other resident's were time. R19 was assist other resident's in the When interviewed of explained that over residents have required total assist would be helpful. No staff not to bring R1 to assist with eating assist one table with time; consequently, transport residents. Interview on 10/4/1 indicated she would also during the week had declined in eating months and now restated she used to p.m. but stopped as her and get cold, we had the cold, we had t	ved that R19 had not yet been a meal yet at this time, 5:48 that waiting to bring resident's who cannot express their sed solely on staff B also agreed that dependent ffered a meal time based on ight loss or previous lifestyle. It is evening meal had less during a day shift meal. p.m. and 6:09 p.m. R19 had not into the dining room for the NA-B left the area to transport from. Dietary staff were the dining room at this time. No the eating their meal at this sted with the meal without any	21045			

Minnesota Department of Health

STATE FORM P7JT11 If continuation sheet 7 of 20

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00755	B. WING		10/0	5/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AF	NGER MEMO N LAKE, MN	DRIAL DRIVE I 56159			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21045	staff would be avail indicated she was a assisted at the end indicated R19's usu 7:00 a.m., noon and could recall. When interviewed a director of nursing a times when we have accommodate a new The DON explained feeding assistance on a verbal complaresident. The DON upset because staff with eating. As a reresidents to the din adding extra staff. 2017 and "we have The DON agreed it dependent resident into the dining room non-verbal resident come later to dining haven't expressed anytime between 5 acceptable to wait is regardless of choice. The DON further in evening NA's take p.m., 5:30 p.m. and access to the kitched therefore, staff start the start of the shift of the breaks according and not resident chopen dining had colored.	lable at that time. FM-B unaware that R19 had been of the meal (6:30 p.m.) FM-B ual routine eating times were d 5:00 p.m. ever since she on 10/5/17, at 1:49 p.m. the (DON) indicated, "There are re had to shift staff to ed, for instance call lights." d the facility was conducting a QA [quality assurance] based int related to an arthritis indicated the resident was f left to assist another resident esult, it was decided to bring ing room in shifts instead of This was initiated on May, 23, en't done anything with it yet." was the non-verbal ts who were transported later in. When questioned how ts were given the choice to g, the DON stated "They it." The DON stated she felt :00 p.m. and 6:30 p.m. was for a meal (open dining),	21045	DELINOTY			

Minnesota Department of Health

STATE FORM P7JT11 If continuation sheet 8 of 20

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00755	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AF	NGER MEMO N LAKE, MN	DRIAL DRIVE 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21045	considered the preferesidents, such as Review of the the faresident Choice Dipurpose was to ensure and meal times. In dementia, or other providing information document efforts to contact family or closure of the director of nursus families regard previous lifestyle are be developed base instead of staff con could be developed experience is based.	derences of non-verbal R19. acility's September 2017 Ining policy indicated its sure resident choice in dining cases where the resident has parriers or challenges to on related to food preferences, learn preferences (e.g. pose friend.) THOD OF CORRECTION: Sing could develop a system to ing choice of meal time and/or and choice. A schedule could don resident' need and choice venience. A quality indicator to ensure the dining	21045			
21530	A. The drug regim reviewed at least more currently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is invavailable through the system. It is not sur	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any	21530			10/26/17

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00755	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AF		DRIAL DRIVE		
(V4) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	N LAKE, MN	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ige 9	21530			
	and the attending p must be acted upon physician visit, or so pharmacist. For pu upon" means the ac report and the signi of nursing services C. If the attend with the pharmacist not provide adequate pharmacist believed being adversely affor refer the matter to to if the medical direct physician. If the me the attending physician does not must be referred for assessment and as by part 4658.0070. the medical direct must refer the matter	director of nursing services obysician, and these reports in by the time of the next coner, if indicated by the arposes of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. ing physician does not concur are recommendation, or does ate justification, and the setted, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter or review to the quality sesurance committee required of the attending physician is or, the consulting pharmacist are directly to the quality essurance committee.				
	by:	ent is not met as evidenced and document review the		Corrected		
	the recommendation monitoring the effect lowering medication the side effects of a medication (Lisinop potassium blood leconcurrent use of A	ure the physician responded to ons of the pharmacist related to ctiveness of a cholesterol (pravastatin), to monitor for an anti-hypertensive oril) with checking the evel and to indicate rationale for aspirin and Coumadin for 2 of 5 (2) reviewed for drug				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00755		B. WING		10/	05/2017
	PROVIDER OR SUPPLIER	- MOUNTAIN LAF	745 BASII		STATE, ZIP CODE DRIAL DRIVE 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	ge 10		21530			
	included a current of milligrams (mg) by vasculopathy (any of The physician orders start date of 4/25/17 R50's care plan lass. The resident has all related to CAD (cor (atrial fibrillation), and Review of R50's me evidence a recent lit to monitor the effect most recent lipid particles and the construction tests (LFT' indicated: Make sur (comprehensive me LFT's) yearly. Howe did not include a rate panel. The Drug Re 9/29/17, included: Fishould be monitore (pravastatin). When interviewed or registered nurse (R panel was complete confirmed the physicial residual panel was complete confirmed the physicial residual residual panel was complete confirmed the physicial residual residual panel was complete confirmed the physician residual	t revised 5/17/17, ind tered cardiovascular onary artery disease	20 y for vessels). uded a dicated: r status e), A-fib include completed atin. The cord was Orug included or liver esponse or includes esponse ng a lipid ort dated ften lipids achol .m. 's last lipid A further d to the				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED		
		00755		B. WING		10/	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AF			RIAL DRIVE		
	T			N LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM,	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	ge 11		21530			
	RN-A also confirme recommendation da physician on 10/4/1 from the physician. When interviewed of director of nursing or record did not include the rationale for not monitor the effective document review of the recommendation of the review of the recommendation of the review of the recommendation of	a lipid panel was not detected by a lipid panel was not detected by a lipid panel was not detected by a lipid panel was not a lipid	t ordered. harmacy xed to the ation yet a.m. the dical b support el to . dated				
	10/3/17, for R62 identified: cervical spine (C-2) fracture, atrial fibrillation, hyperlidemia and hypertension.		and				
	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.						
	6/27/17, and 7/31/1 checking potassium Lisinopril and re-eva Coumadin for atrial	d, Pharmacy Review 7, revealed: recomn (K+) level with use aluate the need for A fibrillation, document (discontinue), cons	mend of Aspirin and nt need for				
	indicated "please co response lacked a r	y response dated 7/6 ontinue". The physic rationale addressing spirin and Coumadi	cian's the				
		acked completion of ssium level related to sinopril.					

Minnesota Department of Health

PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	STATEME	INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
T45 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			00755	B. WING		10/0	5/2017
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) 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	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	GOOD S	SAMARITAN SOCIETY	- MOUNTAIN I AF				
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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
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	21530	Continued From pa	ge 12	21530			
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.		When interviewed of manager (NM)-A consisted been completed for recommendation. For also lacked evidency potassium level has when interviewed of the commendation of the continued administ. Upon interview with 10/5/17, at 10:39 at the expectation for the potassium level in the continued for the potassium of the ongoing order of the consistency of the consulting of the consulting pharmacy policies and procedured as neces pharmacist's review with the pharmacist reviews on a regular TIME PERIOD FOR	on 10/4/17, at 11:04 a.m. nurse onfirmed the labwork had not r R62 per pharmacy Review of the medical record ce that lab tests to evaluate the dibeen completed for R62. on 10/5/17, at 9:27 a.m. the (DON) confirmed the physician the pharmacy ated 6/27/17, related to the distinction for checking a she blood related to the ration of the Lisinopril. In the consulting pharmacist on the physician to address the sium lab work especially with or Lisinopril, which can cause level of potassium), a sect. THOD OF CORRECTION: director of nursing (DON) and cist could review and revise dures for proper monitoring of Nursing staff could be sary to the importance of the w. The DON or designee, along t, could audit medication ar basis to ensure compliance.				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00755	B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AF	NGER MEMO N LAKE, MN	DRIAL DRIVE I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	Continued From pa	nge 13	21540			
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			10/26/17
	monitor each reside unnecessary drug to home's policies and pharmacist must reresident's attending physician does not home's recommendequate justification believes the resident adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, treview to the Qualit (QAA) committee rethe attending physician does not the attending physician does not the order and if the change the order, the attending physician physician does not the quality (QAA) committee rethe attending physician does not the attending physician does not the attending physician does not the quality (QAA) committee rethe attending physician does not the quality (QAA) committee rethe attending physician does not the quality (QAA) and the quality (QAA) and the quality (QAA) and the quality (QAA) are the quality (QAA) and the quality (QAA) and the quality (QAA) are the quality (QA	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the g physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nut's quality of life is being the pharmacist must refer the cal director for review if the not the attending physician. If r determines that the attending have adequate justification for attending physician does not he matter must be referred for ty Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter				
	by: Based on interview facility failed to mor cholesterol lowering failed to monitor for anti-hypertensive m failed to provide ad concurrent use of a	ent is not met as evidenced and document review the nitor the effectiveness of a g medication (pravastatin), r the side effects of an nedication (Lisinopril) and equate indications for aspirin and Coumadin for 2 of 5 2) reviewed for unnecessary		Corrected		
	Findings include:					

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) I

		(X1) PROVIDER/SUPPLII		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00755		B. WING		10/0	5/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAP		NGER MEMO N LAKE, MN	DRIAL DRIVE I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 14		21540			
	included a current of milligrams (mg) by vasculopathy (any of The physician orderstart date of 4/25/17 R50's care plan lass. The resident has all related to CAD (correlated to CAD (correlated to the correlation), and of lipids in blood). Review of R50's me evidence a recent lift to monitor the effective residence and the correlation of the correlation	t revised 5/17/17, index tered cardiovascular conary artery disease and hyperlipidemia (h edical record did not ipid panel had been tiveness of pravasta	20 y for vessels). uded a dicated: r status e), A-fib igh level include completed atin, (treats				
	most recent lipid pa dated 6/16/15.	sterol and triglyceride levels). The at lipid panel located in the record was /15.					
	Regimen Review R a recommendation complete blood cou- function tests (LFT' indicated: Make sur (comprehensive me LFT's) yearly. Howe did not include a rai panel. The Drug Re 9/29/17, included: F	ulting pharmacist's E eport dated 6/26/17, for yearly lab draw funt (CBC), lipids and s). The physician rere he has CBC, CMF etabolic panel which ever, the physician retionale for not ordering imen Review Report of patient on prav	included or liver esponse or includes esponse ng a lipid ort dated ften lipids				
	registered nurse (R panel was complete confirmed the physi	on 10/5/17, at 9:27 a N)-A confirmed R50 ed on 6/16/15. RN- ician did not respond endation dated 6/26/	's last lipid A further d to the				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00755		B. WING		10/	05/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AF			ORIAL DRIVE		
				N LAKE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM,	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21540	Continued From pa	ge 15		21540			
	related to (r/t) a yea rationale as to why	ırly lipid panel nor ga a lipid panel was no					
	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.						
	recommended pota	acked completion of ssium level to monit of related to ongoing sinopril.	or for a				
	manager (NM)-A co	on 10/4/17, at 11:04 onfirmed the lab (K+ I for R62 per pharma	level) had				

Minnesota Department of Health

	AND DIAN OF CORRECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00755		B. WING		10/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAF		NGER MEMO N LAKE, MN	ORIAL DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ' MUST BE PRECEDED BY SC IDENTIFYING INFORM	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21540	recommendation to addition, review of the evidence the potassis monitored. When interviewed of director of nursing (potassium level had R62 had been on Lithat R62 had concurant Coumadin with use especially since responded with the medications. Upon interview with 10/5/17 at 10:39 a.r. important to monito ongoing order for Lithyperkalemia (high dangerous side effects SUGGESTED MET administrator, direct consulting pharmact policies and proced medications. Nursin necessary to the immonitoring. The DC pharmacist, could of basis to ensure consulting consulting consulting pharmacters.	monitor for side effethe medical record a sium level had been on 10/5/17, at 9:27 a DON) confirmed the dinot been monitored isinopril. The DON corrent administration out adequate indicate the physician had reationale for continuate the consulting pharm. it was learned it is rethe potassium level isinopril, which can devel of potassium), ect. CHOD OF CORRECTOR CORRECTOR OF CORREC	.m. the ed while confirmed of Aspirintions for not ing both macist on sel with the cause a TION: The land revise itoring of located as ent and g with the egular	21540	DETIGITION 1		
21635	MN Rule 4658.1350 Medications; Loss of	or spillage		21635			10/26/17
	Subp. 3. Loss or sp	oillage. When a loss	or				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00755		B. WING		10/0	5/2017
	PROVIDER OR SUPPLIER	- MOUNTAIN LAF	745 BASII		STATE, ZIP CODE DRIAL DRIVE I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21635	spillage of a prescrian explanatory notal Schedule II record. by the person responsand by one witness destruction of any responsible. This MN Requirements by: Based on observation review, the facility for developed and implemeded (PRN) narrow residents (R36, R9, blister pack medication carts. Findings include: When the medication was reviewed it was pack of tramadol (not use. The dispensation There were 13 of the blister pack. In pack of tramadol was practical nurse (LPI) the observation, increconciliation of this medication was not potential diversion of drug. When question when the blister pack the times/dates R36 medication from the lit was also noted	ibed Schedule II druation must be made. The notation must be made. The notation must be so that the property of this Schedule IV coned, LPN-A could not be the pack.	in a be signed or spillage erve the ated drug oing up the ridenced ocument stem was le as 4 of 4 d who had 2 s 1 and 2 d a blister s needed) 2017. red from Il blister Licensed nt during to identify controlled iot identify ensed) nor otic	21635	Corrected		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		00755		B. WING		10/	05/2017	
	PROVIDER OR SUPPLIER	- MOUNTAIN LAF	745 BASII	DDRESS, CITY, STATE, ZIP CODE SINGER MEMORIAL DRIVE AIN LAKE, MN 56159				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21635	that one of the table the packaging. LPI the back of the blist unable to administeresident and/or if the been popped from "gone anywhere ne Review of the mediand 4 identified that tramadol narcotic peen routinely recodispensed of the 16 blister pack dated 8 remaining of the 30 dispensed to the fasystem for staff to radministered to R9 Review of the facility Acquisition, Receiv of Medications policand other drugs sul reconciled at least a systems of record reconciled at least a system or record reconciled at least a system of record record reconciled at least a system of record	ets had been taped be N-A stated that staff of the pack when they have the medication has accepted by the blister pack, but have the blister pack, but har the resident". cation carts used for tagged by the medication that have the resident had a dos total tablets located by 1/17. R9 had 10 dos total tablets located by 1/17. R9 had 10 dos tablets of tramadol to cility on 4/28/17. The reconcile the PRN dos and R11. by's September 2016 ing, Dispensing, and by indicated Controlle bject to possible abust daily through an appreceipt and disposition ckaged according to disposition of classifications. New labels will be was no mention of cleantegrity of the medical	often tape ave been ne cidently nadn't halls 3 d PRN ad not ses in the ses hat were re was no ses Storage of drugs se will be opriate n. All State e applied eanliness ation TION: The and revise ge, and uld be e of	21635				

Minnesota Department of Health

STATE FORM P7JT11 If continuation sheet 19 of 20

PRINTED: 10/30/2017

Minneso	ta Department of He	alth			FORM A	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00755	B. WING		10/0	5/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNIAIN I AF	NGER MEMO IN LAKE, MN	ORIAL DRIVE N 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21635	Continued From pa	ge 19	21635			
	along with the pharm medications on a re compliance.	macist, could audit egular basis to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one				

F5549028

PRINTED: 10/31/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245549 B. WING 10/04/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 745 BASINGER MEMORIAL DRIVE **GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE MOUNTAIN LAKE, MN 56159** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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

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.

Event ID: P7JT21

PRINTED: 10/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245549	B, WING		10/	04/2017	
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE COMPLET		
K 000	Angela.Kappenman < mailto:Angela.Kap THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of y to correct the deficit 2. The actual, or pr 3. The name and/oresponsible for comprevent a reoccurre Building 01 of Good Lake was construct The original buildin one-story, has no be protected and was II(000) construction The 1995 building a basement, is fully fidetermined to be of the 2013 link additt no basement, is fully fidetermined to be of the 2013 link additt no basement, is fully was determined to construction. Therefore the treatment areas local addition is separated.	state.mn.us itney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH of INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. d Samaritan Society Mountain ted as follows: g was constructed in 1976, is easement, is fully fire sprinkler determined to be of Type or eaddition is one-story, has no ire sprinkler protected and was f Type II(000) construction; addition is one-story, has no ire sprinkler protected and was f Type II(000) construction. ion is one-story in height, has ly fire sprinkler protected, and	KO				

PRINTED: 10/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245549	B WING		10/	04/2017
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159			
(X4) ID PREFIX T A G	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	building as allowed Fire Protection Ass Life Safety Code (L Health Care Occup The facility has a fi detection in the cor corridors which is r department notifical	e being surveyed as one in the 2012 edition of National ociation (NFPA) Standard 101, .SC), Chapter 19 Existing	K 000			
K 133 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: K 133 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			10/23/17
				K133 MULTIPLE OCCUPANCIES The penetration between the nurs home and the AL building was res	sing	

PRINTED: 10/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245549	B. WING_		10/	04/2017
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX T A G	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETION DATE	
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		K 13			
	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.					