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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: PEY2

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00755

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245549**
2.STATE VENDOR OR MEDICAID NO.
(L2) **477840500**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/04/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

12.Total Facility Beds **55** (L18)
13.Total Certified Beds **55** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Connie Brady, HFE NE II — 04/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist 05/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

CMS Certification Number (CCN): 245549

May 1, 2017

Ms. Anne Reese, Administrator
Good Samaritan Society, Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

Dear Ms. Reese:

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 March 25, 2017 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

Electronically delivered

May 1, 2017

Ms. Anne Reese, Administrator
Good Samaritan Society, Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

RE: Project Number S5549027

Dear Ms. Reese:

On March 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 16, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 4, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 20, 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 February 16, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 16, 2017, effective March 25, 2017 and therefore remedies outlined in our letter to you dated March 7, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 245549 Y1 | A. Building<br>B. Wing Y2 | 4/4/2017 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE | 745 BASINGER MEMORIAL DRIVE<br>MOUNTAIN LAKE, MN 56159 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix F0248 | Correction | ID Prefix F0279 | Correction | ID Prefix F0311 | Correction |
| Reg. # 483.24(c)(1) | Completed | Reg. # 483.20(d);483.21(b)(1) | Completed | Reg. # 483.24(a)(1) | Completed |
| LSC | 03/25/2017 | LSC | 03/25/2017 | LSC | 03/25/2017 |
| ID Prefix F0315 | Correction | ID Prefix F0329 | Correction | ID Prefix F0371 | Correction |
| Reg. # 483.25(e)(1)-(3) | Completed | Reg. # 483.45(d)(e)(1)-(2) | Completed | Reg. # 483.60(i)(1)-(3) | Completed |
| LSC | 03/25/2017 | LSC | 03/25/2017 | LSC | 03/25/2017 |
| ID Prefix F0428 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 483.45(c)(1)(3)-(5) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 03/25/2017 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| | KS/kfd | 4/28/2017 | 28651 | 4/4/2017 |
| **REVIEWED BY CMS RO** ☐ | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |

**FOLLOWUP TO SURVEY COMPLETED ON**
2/16/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 245549 Y1 | A. Building 01 - MAIN BUILDING 01<br>B. Wing Y2 | 3/20/2017 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE | 745 BASINGER MEMORIAL DRIVE<br>MOUNTAIN LAKE, MN 56159 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0133 | 02/15/2017 | LSC K0291 | 02/20/2017 | LSC K0300 | 02/21/2017 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC K0918 | 02/21/2017 | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | LSC | | LSC | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| | TL/kfd | 4/28/2017 | 35482 | 3/20/2017 |
| **REVIEWED BY CMS RO** ☐ | **REVIEWED BY (INITIALS)** | **DATE** | **TITLE** | **DATE** |

**FOLLOWUP TO SURVEY COMPLETED ON**
2/14/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: PEY2

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00755

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/16/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
**X** 1. Acceptable POC

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Jennifer Kolsrud, HFE NE II — 03/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 04/24/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 7, 2017

Ms. Anne Reese, Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

RE: Project Number S5549027

Dear Ms. Reese:

On February 16, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

**Kathryn Serie, Unit Supervisor**
**Health Regulation Division**
**Minnesota Department of Health**
**1400 E. Lyon Street**
**Marshall, Minnesota 56258**
**Email: Kathryn.serie@state.mn.us**
**Office: (507) 476-4233** **Fax: (507) 537-7194**

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 March 28, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 28, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 16, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 16, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. 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,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 248 SS=D | 483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>(c) Activities.<br><br>(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide an individualized activity program for 1 of 1 non-English speaking resident (R28) reviewed for activities.<br><br>Findings include: | F 248 | F248 ACTIVITIES MEET INTEREST OF EACH RES<br>Resident #28 has been re-interviewed regarding her activity interests with the use of an interpreter. This interpreter has been secured to be available every few weeks and as needed to talk with Res #28 | 3/25/17 |

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

Electronically Signed | 03/16/2017

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 1<br><br>R28 was admitted 4/4/14 according to the admission record, with diagnoses which included: hemiplegia-left non-dominate side, major depressive disorder, chronic pain, and weakness.<br><br>The most recent annual Minimum Data Set (MDS) assessment was dated 11/10/16. The MDS identified R28 received extensive assistance from staff with bed mobility, dressing, eating, toileting, and personal hygiene; and total assistance for transfers and locomotion on and off the unit. The MDS identified preferences for customary routine and activities included listening to music, news, religious services, and group activities as somewhat important. Going outside was not very important.<br><br>The Care Area Assessment dated 11/17/16, included: no delirium, decreased ability to make self understood or to understand others - resident has limited understanding of complex concepts which is exacerbated by the fact that she is illiterate and her English proficiency was very limited. She was a poor historian, but able to convey her basic needs and preferences. The CAA further identified R28 had a history of depression. R28's communication was impaired related to her ability to understand others through verbal content.<br><br>R28's care plan dated 4/14/14, indicated R28 had little or no activity involvement related to (R/T) long-standing history (hx) of spending time alone and currently low interest level in activities offered due to (D/T) communication barriers and cultural differences. Interventions included enjoys visits with family, encourage frequent visits, preferred watching Laotian TV shows, English game and | F 248 | and ascertain if there are any issues and determine preferences for her activities. Staff will offer groups and other activities and allow the resident to choose and express preferences daily. Res #28 maintains that her spiritual needs are met through programs on TV, which are in her native language. The care plan has been reviewed and updated to reflect any changes expressed through these interviews.<br><br>Activity Interest Data Collection Tools were also reviewed and updated for all other residents<br>who have communication difficulties and cannot readily voice their wants and desires. Families were enlisted to assist when a resident was not able to communicate due to communication difficulties, such as cognitive losses.<br><br>Activity staff were re-educated on 3/14/17 re: the need to be aware of the current care plan for each resident and to provide opportunities for each resident to be invited and made aware of activities of interest to them and as they desire. All staff were educated on 3/14/17 – 3/15/17 on the need to be aware of opportunities to offer involvement in activities for all residents, and especially Res #28, and remind them to document all offers of activities and the resident response to the offers. Those unable to attend these meetings will be contacted and educated on an individual basis.<br><br>Audits will be done on 2 residents per | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 2<br>animal shows and praying 2x/day as per her religion, offer 2-1:1 visits/week, and encourage to go outdoors during pleasant weather.<br><br>Documentation by the licensed social worker (LSW) dated 11/10/16, identified R28's primary language was Laotian and she was able to understand and speak a few words and simple phrases in English. R28 was able to verbalize basic needs with either words/phrases or by making gestures. R28 had limited education in her own culture which affected comprehension. Laotian speaking staff identified R28 didn't understand certain concepts due to (d/t) cultural differences.<br><br>The Activity Interest Data Collection Tool - V 2 dated 11/14/16, identified it to be an annual assessment. Television was the only interest identified and the summary indicated responses were provided by family/other. The tool identified a language barrier as R28 didn't read either English or Lao. It identified R28 spoke Lao, communicated with facial expressions and motions, and spoke simple words in English. The activity log identified R28 was social as she went to the dining room for meals.<br><br>On 2/13/17, at 5:20 p.m. R28 stated she didn't understand what was going on in the community so she often stayed in her room. She further indicated there were not activities provided that she liked, and no arrangements were made to allow her to be able to participate in the ones she did enjoy. R28 indicated she could go outside when the weather was nice, but sometimes she didn't want to go outside.<br><br>F-A was interviewed with R28 on 2/14/17, at | F 248 | week X 3 months and then randomly thereafter, by the Activity Director or her designee to determine if each resident is being informed of and invited to activities of their choice or offered alternatives. Results of these audits will be reported at the monthly QAPI meetings and any issues identified will be addressed by the QAPI Team as necessary. Completion Date: 3/25/17 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 3 | F 248 | | |

12:15 p.m. and translated questions for R28 in addition to offering input on R28's preferred activities. F-A and R28 indicated preferred activities included music, spiritual programs, watching Laotian programs and some English programs on TV. Both F-A and R28 indicated they were not certain if there were facility activities she would like or not.

During continuous observation of R28 on 2/14/17, from 10:49 a.m.- 12:52 p.m. the following was noted:
-10:49 a.m. R28 was seated in her wheelchair (w/c) in her room in front of the TV which was tuned to a Laotian channel. R28 looked at the TV, look around the room, and then closed her eyes.
-11:52 a.m. NA-B entered R28's room, touched her on the shoulder, and told R28 it was time for lunch. R28 looked at her, smiled, and NA-B transported her to a dining room table. R28 was seated at the table with 4 other residents and staff persons who were assisting them with their meal. R28 was observed in the dining room from 11:55 a.m. - 12:15 p.m. and the only interaction noted between R28 and staff was when she was provided her plate of food, offered dessert, and when NA-A removed her clothing protector and assisted her from the dining room. Neither staff or other residents interacted with R28 when she was at the dining room table.
-12:15 p.m. as R28 was transported from the dining room to her room, F-A was waiting in the lounge area and accompanied R28 to her room. F-A agreed to interpret questions for R28 and indicated he usually visited daily. When asked about foods and activity, F-A indicated R28 was not able to understand what was going on, so she didn't attend. When asked why she had not eaten

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 4 | F 248 | | |

her meal, R28 indicated she didn't like what she was served.
-12:30 p.m. NA-A and NA-B transferred R28 into bed with the sling lift.
-1:15 p.m. R28 was in bed with eyes closed, and F-A seated at bedside.

During continuous observation of R28 on 2/15/17, from 10:16 a.m. - 12:15 p.m.:
-10:16 a.m. R28 was seated in her w/c in front of her TV in her room. R28's eyes were closed and she appeared to be sleeping.
-11:14 a.m. R28 continued sitting in her w/c in her room with the TV on and eyes closed. No attempts to invite her to an activity or socialize were noted. NA-A stopped in room, and greeted resident, who looked at NA-A and smiled. NA-A placed items in closet and left room.
-11:44 a.m. R28 was transported by the restorative NA to the dining room and positioned at the table. Two other residents were at the table being assisted by staff. R28 watched the residents being assisted to eat, and at 11:53 a.m. was served her meal. R28 picked up her spoon and fed herself approximately 1/2 teaspoon of corn and then placed the spoon down. R28 watched the other residents being assisted by staff, but no one was noted to interact with R28, who after a short time closed her eyes.
-12:01 p.m. R28 had not attempted to eat, and continued to sit and look at other people around her.
-12:04 p.m. R28 was transported from the dining room back to her room. F-A was in the lounge, greeted R28 and transported her to her room. R28 was communicating with F-A and smiling and laughing.

F-A was interviewed with R28 on 2/14/17, at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 5 | F 248 | | |

12:15 p.m. and translated questions for R28 in addition to offering his input on R28's preferred activities. F-A and R28 indicated preferred activities included music, spiritual programs, watching Laotian programs and tapes and some English programs on TV. As for activity programs provided by the facility; both F-A and R28 indicated they were not certain if there were activities she would like or not. F-A and R28 indicated they did not recall an assessment being conducted as to R28's preferences or likes/dislikes related to activities.

On 2/14/17, and 2/15/17, R28 remained in her room, other than when she was transported to the dining room for meals. Although News and Stretch was identified as a daily activity of interest identified for R28, she remained in her room while this activity occurred. There was no documentation indicating R28 had been invited or refused to attend the activity. Although music was identified as an interest for R28, on 2/15/17, at 2:00 p.m. a rthymn band activity was provided in the activity room and R28 remained in her room

Review of activities and attendance records for January and February 2017, in addition to an interview with the activity director (AD) on 2/15/17, at 3:21 p.m. indicated there was not a schedule for 1:1 and/or social visits. The activity director indicated a picture chart for communication had been attempted, but was no longer in use. The AD indicated she had a "file" of communication ideas, but they hadn't been implemented/attempted. The AD indicated R28 had been having a lot of pain and remained in bed a lot of the day. The AD stated R28 was transported to the activity room for news/exercise when she wanted to attend, and at times would

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 6 | F 248 | | |

participate by mimicking other residents. The AD further indicated at times R28 would just watch what was occurring. The AD indicated R28 watched a lot of Laotian TV and received social contact by having her meals in the dining room. The AD indicated additional activities provided for R28 were manicures and/or hand massages when she would allow these activities to be provided, but further indicated R28 didn't show any indication of wanting to attend additional facility activities.

On 2/15/17, at 3:52 p.m. activity aides (AA)-A and AA-B were interviewed and indicated they had not invited R28 to the music activity which took place at 2:00 p.m. that afternoon. When asked why R28 hadn't been included, both AA-A and AA-B indicated they had forgotten and were not certain if R28 would have enjoyed the activity. AA-A and AA-B further indicated when they attempted to invite R28 to an activity they had to "act out" using hand motions in an attempt to explain what they were asking. AA-A indicated they were uncertain if R28 was able to understand what they attempted to ask her and then indicated they probably should attempt/inviting R28 to more activities.

R28's Progress note dated 2/15/17, identified the care plan goals were met via: 1:1 visits from staff, family, watching TV, beauty shop visit and manicure. Will continue care plan as written. There were no activity progress notes for 1/17, to indicate any programs or interventions were provided/attempted. Documentation dated 12/2/16, VHS player and tapes previously provided by son were taken home by son. There was no indication that the facility had provided tapes or recordings to replace the items that were

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 248 | Continued From page 7<br>taken home. Review of the activity documentation identified no group activities, and of the 15 activity occurrences documented all were 1:1 activity in 1/17. One of 15 instances of 1:1 activity was provided after 1:00 p.m. Of the 1:1's provided in 2/17, one occurrence was after 1:00 p.m. For afternoons/evenings (after 4:00 p.m.) and weekends there was no documentation of activities being provided for R28.<br><br>On 2/16/17, at 11:39 a.m. the director of nursing (DON) and administrator were interviewed related to providing education to staff in working with non-English speaking residents, and meeting the social and activity needs of those residents. The DON indicated no special training had been provided and the facility primarily utilized family members and Laotian speaking employees to interpret when they were available. | F 248 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that | F 279 | | 3/25/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 279 | Continued From page 8 | F 279 | | |

includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 279 | Continued From page 9<br>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to develop a care plan related to incontinence for 1 of 2 (R62) residents reviewed who had a change in continence.<br><br>Findings include:<br><br>R62 was admitted to the facility 9/13/16, with diagnoses including benign prostatic hypertrophy and malignant neoplasm of the prostate.<br><br>Review of the admission assessment dated 9/13/16, identified R62 as not being continent and experiencing dribbling and leaking. The bladder assessment dated 1/20/17, identified R62 as having functional incontinence secondary to other factors (e.g. physical weakness, cognitive impairment, medication, environmental impediments). No recommendations were identified.<br><br>Review of the current care plan dated 9/13/16, did not address R62's incontinence. The care plan identified toilet use: strength: uses urinal at night, assist with placement and emptying prn (as needed).<br><br>During interview with registered nurse (RN) A on 2/14/17, at 1:29 p.m. she stated R62 was incontinent. She verified that the care plan did not identify the incontinence nor was there a toileting plan.<br><br>During interview on 2/16/17, at 9:38 a.m. the | F 279 | F279 DEVELOPMENT OF COMPREHNSIVE CARE PLANS<br>Resident #62 has had a new Bladder Incontinence Data Collection Tool completed and also a new comprehensive Bladder Assessment. His Care Plan has been reviewed and updated to coincide with the data collected and a toileting program has been developed to meet his needs.<br><br>Care Plans for all other residents who have documented incontinence were reviewed and updated as necessary to reflect their current needs.<br><br>All nursing staff were educated on 3/14/17 □ 3/15/17 on the need for accurate documentation of each resident□s level of continence, offering toileting assist and communicating changes in toileting needs. Any nursing staff not able to attend this training will be contacted and educated on an individual basis. Education and discussions was held with Case Managers to evaluate our assessment processes and periodic reviews.<br><br>Audits will be done every month x 3 months on care plans for 3 residents and then 1 resident care plan per month for the next 3 months by the Director of Nursing, or her designee, on residents | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 279 | Continued From page 10<br>director of nursing verified that no care plan had been developed regarding R62's incontinence and no toileting plan had been developed related to the incontinence.<br><br>The Procedure Bladder Assessment revised 5/16, identified care plan interventions should be individualized based on the Care Area Assessment and modified as appropriate based on an assessment/evaluation of the resident's response to the interventions and success with attaining/maintaining bladder continence. | F 279 | who have incontinence or changes in their continence level to determine if they have been assessed and the care plan is accurate according to their needs. Results of these audits will be reported at the monthly QAPI meetings and any issues identified will be addressed by the QAPI team as necessary. Completion Date: 3/25/17 | |
| F 311 SS=D | 483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS<br><br>(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide services necessary to facilitate communication between staff and resident for 1 of 1 (R28) identified as non-English speaking.<br><br>Findings include:<br><br>R28's was admitted 4/4/14. The current electronic diagnosis list included: hemiplegia-left non-dominate side, major depressive disorder, chronic pain, type II diabetes, and weakness.<br><br>Multiple communication concerns for R28 were identified during survey as noted below. These included R28 spoke only Laotian and was unable | F 311 | F311 TREATMENTS AND SEVICES TO MAINTAIN ADL'S<br>Resident #28 has been re-interviewed regarding activity interests, food choices, daily needs, etc.<br>with the use of an interpreter. This interpreter has been secured to be available every few weeks and as needed to talk with Res #28 and ascertain if there are any issues and determine preferences and daily plan of care. This interpreter has also provided insight into cultural and religious customs to be used to educate staff in order to better provide complete care for Res #28. | 3/25/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 311 | Continued From page 11<br>to read in either English or Laotian. Staff and R28 had developed a limited method of communication by words and/or gestures. There were two staff who spoke Laotian, but they were not always available. The previously utilized interpreter was no longer employed by the facility and assisted on an intermittent basis. R28 spent the majority of her time isolated in her room due to not understanding programs/activities and no accommodations to allow her to participate. Interviews indicated a board for communication was posted in R28's room for a short time but went missing and was not replaced. R28 took her meals in the dining room, but staff and residents did not interact with her during the meal. R28 ate only bites of food, and received no prompting or questions about food/appetite.<br><br>The most recent annual Minimum Data Set (MDS) assessment was dated 11/10/16. The MDS identified R28 received extensive assistance from staff with bed mobility, dressing, eating, toileting, and personal hygiene; and total assistance for transfers and locomotion on and off the unit. The MDS identified preferences for customary routine and activities included listening to music, news, religious services, and group activities as somewhat important. Going outside was not very important.<br><br>The Care Area Assessment dated 11/17/16, included: no delirium, decreased ability to make self understood or to understand others - resident has limited understanding of complex concepts which is exacerbated by the fact that she is illiterate and her English proficiency was very limited. She was a poor historian, but able to convey her basic needs and preferences. The CAA further identified R28 displayed impulsive | F 311 | Plans of care for all other residents with communication issues, either from lack of speech or cognitive issues, have been reviewed to determine if they have had adequate opportunities to express their needs and preferences, either through interview or with assist of family.<br><br>All staff were educated on 3/14/17 and 3/15/17 on diversity in residents, such as language differences, cultural differences, religious choices, and other differences and the need to recognize these differences and accommodate them. Specific items were included re: the religious and culture of Res #28. Staff not available on these days will be contacted and educated on an individual basis.<br><br>Audits will be done monthly on all new residents with communication problems for the next 6 months to determine if all avenues have been explored to provide them the opportunity to have their needs expressed. Audit results will be reported at the monthly QAPI meetings and any issues identified will be addressed by the QAPI team. Completion Date: 3/25/17 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 311 | Continued From page 12 | F 311 | | |

behavior in that she was quick to strike out at staff when not liking something or experiencing pain. R28 had a history of depression, chronic pain, and was dependent on staff due to physical disabilities. R28's communication was impaired related to her ability to understand others through verbal content.

Documentation by the licensed social worker (LSW) dated 11/10/16, identified R28's primary language was Laotian. She was able to understand and speak a few words and simple phrases in English. R28 was able to verbalize basic needs with either words/phrases or by making gestures. Translation services were provided as needed (prn); however, comprehension is limited at times even with translation. R28 has limited education in her own culture which affects comprehension. R28 was described as, "a simple person". Laotian speaking staff also explained that R28 didn't understand certain concepts due to (d/t) cultural differences. The LSW progress note dated 2/8/17, indicated R28 was not able to complete the interview portion of the assessment due to the language barrier and history of difficulty following the questions when attempted in the past. Family member (F)-A and her primary nursing assistant (NA) were consulted to complete the assessment information.

The care plan printed as current on 2/16/17, identified a communication problem because of the language barrier. The care plan identified the interventions of provide translator as necessary to communicate with the resident - utilize family and staff who are fluent in Laotian "when available", utilize communication techniques which enhance interaction, and use alternative

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 311 | Continued From page 13 | F 311 | | |

communication tools as needed such as props, gestures and pictures - adjust as needed. Although the care plan identified basic interventions to use with R28, there were no resident specific interventions to guide staff on what to do when the interventions didn't work such as when family/Laotian staff not available and when the communication form on the wall disappeared or how to "adjust as needed".

R28 was interviewed on 2/13/17, at 5:20 p.m. with the aide of a Laotian speaking interpreter. R28 stated she didn't understand what was going on in the community so she often stayed in her room. She further indicated there were not activities provided that she liked, and no arrangements were made to allow her to be able to participate in the ones she did enjoy. R28 indicated she could go outside when the weather was nice, but sometimes she didn't want to go outside. During the interview, R28 indicated she had a problem with a nursing assistant (NA) and requested to not to work with her anymore. R28 indicated she attempted to report the concern, but, staff didn't understand what she was trying to communicate. R28 further indicated she had told family member (F)-A and he talked to staff. R28 stated [F-A] said, "don't complain, just be patient". R28 stated she told [F-A] "I don't want to live, I want to die. I sleep, I have pain. [F-A] said I have to be patient."

F-A was interviewed with R28 on 2/14/17, at 12:15 p.m. and translated questions for R28 in addition to offering input on R28's preferred activities. F-A and R28 indicated preferred activities included music, spiritual programs, watching Laotian programs and some English programs on TV. Both F-A and R28 indicated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 311 | Continued From page 14 | F 311 | | |

they were not certain if there were facility activities she would like or not.

On 2/15/17, at 11:00 a.m. with the LSW indicated communication with R28 is provided via a staff person that is able to speak her language or a family member and she received adequate information in this manner. The LSW further indicated R28's family member visits about every day and the facilty had a telephone interpreter service available for emergency situations. The LSW indicated R28 has not voiced any concerns in over a year.

NA-A was interviewed on 2/15/17, at 11:33 a.m. and indicated she was not aware of R28 attending any activities. NA-A indicated R28 normally returned to her room after breakfast and watched TV in her native language. NA-A stated communication was accomplished by staff and R28 picking up on words and gestures. NA-A indicated R28 would utilize her call light when she needed something. NA-A further indicated family visited frequently and would communicate R28's needs if staff didn't understand something.

On 2/15/17, at 12:14 p.m. the director of nursing (DON) indicated she was not aware of any recent concerns regarding communication with R28. The DON stated R28 did not want to sit on the toilet and wanted to lie down in bed have an incontinent bowel movement (BM). When staff would attempt to turn and reposition in order to provide care, R28 would become upset. The DON indicated they had attempted to give an explanation via a person who spoke her language, but it didn't help. The DON stated R28 was not toileted related to (r/t) a lack of understanding and not liking to sit on the toilet.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 311 | Continued From page 15 | F 311 | | |

The DON further indicted the toileting issue came up a year previously. When asked about communication with R28, the DON stated R28 knew some English words and gestured to indicate needs.

On 2/15/17, at 3:21 p.m. the activity director (AD) indicated a picture chart for communication had been attempted, but was no longer in use. The AD indicated she had a "file" of communication ideas, but they hadn't been implemented/attempted.

On 2/14/17, at 11:52 a.m. R28 was seated in her w/c positioned at the table in the dining room. R28 was served beverages and drank independently. A plate containing a meat patty, mashed potatoes with gravy, and carrots was placed in front of R28. R28 looked up at the aide and then down at her plate, picked up her fork and moved her carrots around on her plate. She took two bites of carrots and then laid the fork down. R28 looked around the table at four other residents being assisted by staff and at other residents and staff in the dining room. No staff offered to assist R28 by offering an alternate food or encouraging her to eat. R28 sat with no staff or resident interaction the entire time she was in the dining room. At 12:10 p.m. a staff person transported her out of the dining room. F-A was waiting to visit with R28 when she arrived back to her room. F-A translated for R28 who was asked why she hadn't eaten her dinner. R28 replied that she didn't like it and added she frequently received mashed potatoes and she didn't like potatoes. She further indicated staff was aware of this, but she still received them regularly. F-A further indicated family members brought food in sometimes and R28 ate very well at those times.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 311 | Continued From page 16 | F 311 | | |

F-A indicated he was not aware of any discussions having been held regarding R28's food preferences. F-A indicated R28 had minimal understanding of English and there had been a paper on the wall which contained photos of objects R28 might need/want, and could be used to assist with communication, but it had disappeared and not been replaced. R28 stated the same thing on 2/13/17, at 5:00 p.m. during the initial interview with a Laotian speaking interpreter and was confirmed by F-A.

During an interview with F-A on 2/14/17, at 12:07 p.m. it was indicated R28 didn't eat very much as she didn't like the food and preferred oriental type foods. F-A further indicated family members brought food in sometimes and R28 ate very well at those times. F-A indicated he was not aware of any discussions having been held regarding R28's food preferences. F-A indicated R28 had minimal understanding of English and there had been a paper on the wall which contained photos of objects R28 might need/want, and could be used to assist with communication, but it had disappeared and not been replaced.

On 2/15/17, at 11:44 a.m. R28 was transported to the dining room and positioned at the table. Two additional residents with staff persons assisting them were already at the table. Neither staff or residents attempted to interact with R28 during the time she was seated at the table. R28 drank her coffee without assistance, and looked around at the other persons seated at the table and moving about in the dining room. R28 closed her eyes and appeared to be asleep, no staff were observed attempting to interact with R28. At 11:53 a.m. R28 was served a meal of shredded roast beef, mashed potatoes with gravy, and corn. R28

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 311 | Continued From page 17 | F 311 | | |

picked up her spoon, took one bite of corn and set the spoon down. No staff offered an alternate food, or encouraged R28 to eat. R28 continued to sit and look around the room at other persons eating until 12:04 p.m. when a staff person walked over to R28, spoke to her, (asked if she wanted to go to her room), R28 smiled, the staff member removed her clothing protector, and transported her from the dining room. F-A was waiting in the lounge area and transported R28 to her room. F-A translated for R28 and when asked about her noon meal R28 stated she didn't like it. F-A indicated R28 preferred foods from her culture and that she didn't like potatoes and wanted, "sticky" rice. F-A indicated he thought R28 would eat better if she liked the food.

On 2/15/17, at 5:45 p.m. R28 was seated at the assisted dining room table with an untouched hamburger cut up on a plate in front of her. In addition she had peaches/Jello, and had eaten only bites and taken sips of her fluids. R28 looked up but was unable to state whether she liked the food. Although a NA was seated at the end of the table helping another resident, there was no prompting R28 to eat or offering other food options.

On 2/16/17, at 8:46 a.m. R28 was seated at the breakfast table feeding herself hot cereal, toast, and coffee. Dietary aide (DA)-B and DA-C were serving breakfast to residents and indicated R28 really liked breakfast. DA-B indicated R28 would frequently eat two bowls of oatmeal in the am. They stated this morning R28 had eaten a poached egg, and sometimes would eat yogurt with her cereal. DA-C indicated R28 had previously been offered hot cereal when she requested. DA-C further indicated R28's English

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 311 | Continued From page 18<br>was limited, but she did know how to say "oatmeal".<br><br>On 2/16/17, at 11:56 a.m. the director of nursing (DON) and administrator were interviewed and indicated staff were trained to work with R28 by working with another NA. While working with another aide, they would observe how the other aide communicated with R28. The DON indicated there was no specific for training for communicating with non-English speaking persons. When asked to explain, the DON stated, "like doing personal cares" was how they would learn her preferences. The DON indicated they had tried a picture board and that didn't work, and she was not aware of any other options attempted. When asked if there was any therapy involvement for communication, the DON responded "not anything that I'm aware of". At 12:20 p.m. the DON indicated the facility used to have an interpreter who was also an employee but was now working through the clinic. The DON indicated the facility would attempt to telephone her when she was needed, but they didn't always receive a response. The DON and administrator were asked regarding the provision of visual interpretive services since facility had attempted a telephone service but R28 didn't like it. The DON stated they hadn't thought of other options but it was definitely something they could look into. When asked if they had attempted seeking social and interpretive services through the large Laotian community, The DON stated she was not aware of any attempts to work with the Laotian community. | F 311 | | |
| F 315 SS=D | 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER | F 315 | | 3/25/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 315 | Continued From page 19<br>(e) Incontinence.<br>(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br><br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and<br><br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to assess and implement | F 315 | F315 PREVENT / RESTORE BLADDER CONTINENCE | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 315 | Continued From page 20<br>interventions for bladder incontinence for 1 of 2 residents (R62) reviewed for urinary incontinence.<br><br>Findings include:<br><br>R62's admission minimum data set (MDS) dated 9/20/16, identified R62 was occasionally incontinent (less than 7 episodes of incontinence in the look back period) and required extensive assistance of one staff with toileting. The Care Area Assessment (CAA) identified R62 as having occasional bladder incontinence, needing assistance with toileting, dependent on staff for assistance transferring to/from toilet and able to verbalize need to use toilet. The CAA also identified R62 as dribbling urine before getting to the toilet. The CAA identified R62 would be encouraged to call for assistance to the toilet immediately when feeling the urge to void to reduce waiting time and risk of incontinence and that urinary incontinence would be addressed on the care plan. The quarterly MDS dated 12/15/16, identified R62 as being frequently incontinent (7 or more episodes of incontinence but at least one episode of continence) and needing extensive assistance of one staff with toileting. R62 had diagnoses which included benign prostatic hypertrophy and malignant neoplasm of the prostate.<br><br>Review of the admission assessment dated 9/13/16, identified R62 as not being continent and experiencing dribbling and leaking. The bladder assessment dated 1/20/17, identified R62 as having functional incontinence secondary to other factors (e.g. physical weakness, cognitive impairment, medicaiton, environmental impediments). No recommendations were identified. Review of the care plan dated 9/13/16, | F 315 | Resident #62 has had a new Bladder Incontinence Data Collection Tool completed and also a new comprehensive Bladder Assessment. His Care Plan has been reviewed and updated to coincide with the data collected and a toileting program has been developed to meet his needs.<br><br>Care Plans for all other residents who have documented incontinence, and especially those with a decline in their level of continence, were reviewed and updated as necessary to reflect their current needs and insure there are approaches in place to promote continence or establish an acceptable toileting program.<br><br>Nursing staff were educated on 3/14/17 – 3/15/17 on the need for accurate documentation of each resident's level of incontinence, offering timely toileting assist, and encouraging residents to accept assistance according to their plan. Education and discussions was held with Case Managers regarding the assessment process for bladder incontinence.<br><br>Audits will be done every month x 3 months on care plans for 3 residents and then 1 resident care plan per month for the next 3 months, by the Director of Nursing, or her designee, on residents who have incontinence or changes in their continence level to determine if they have been assessed and the care plan is accurate according to their needs. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 315 | Continued From page 21<br>identified it failed to address R62's incontinence. The care plan identified R62 used the urinal at night, assist with placement and emptying prn (as needed).<br><br>During interview on 2/14/17, at 1:41 p.m. nursing assistant (NA)-A stated that R62 was always incontinent of urine in the morning and probably half continent and half incontinent during the day.<br><br>During interview on 2/14/17, at 1:29 p.m. registered nurse (RN)-A stated R62 was incontinent. She stated it varied depending on R62's pain, strength and how long he had to wait for staff assistance. She stated R62's incontinence had increased since admission "as he has to wait for assistance." She verified no toileting program was in place.<br><br>During interview on 2/16/17, at 9:38 a.m. the director of nursing verified that R62's continence had changed since admission and that no interventions had been put into place and no toileting plan had been developed related to the incontinence.<br><br>The Procedure Bladder Assessment revised 5/16, identified that an appropriate toileting program should be determined based on the bladder incontinence data collection tool and bladder assessment. | F 315 | Results of these audits will be reported at the monthly QAPI meetings and any issues identified will be addressed by the QAPI team as necessary. Completion Date: 3/25/17 | |
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- | F 329 | | 3/25/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 329 | Continued From page 22<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure appropriate lab monitoring for a diuretic was conducted for 1 of 5 residents (R13) reviewed for unnecessary | F 329 | F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>The physician for Resident #13 was contacted and the decision was made to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 329 | Continued From page 23<br>medications. In addition, the facility failed to ensure a timely follow-up of the consultant pharmacist suggestion related to the use of an antidepressant was for conducted for 1 of 5 residents (R16) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R13's face sheet, dated 2/16/17 identified diagnoses of Parkinson's disease and edema.<br><br>R13's quarterly minimum data set, dated 12/14/16 identified a terminal prognosis, and identified R13 was non-verbal and totally dependent on staff for cares. A care area assessment (CAA) for dehydration/fluid maintenance was not triggered.<br><br>R13's physician's orders, dated 2/16/17 identified an order for Lasix (a diuretic used to control fluid balance that can significantly deplete potassium levels in the blood) 40 milligrams (mg) daily for edema, with a start date of 12/23/16. No routine lab work was ordered to monitor R13's electrolytes and no potassium supplement was ordered.<br><br>R13's medication administration record, dated 2/17 identified R13 was still receiving the Lasix on a daily basis.<br><br>A review of R13's chart did not reveal any electrolyte labs being drawn within the previous 12 months.<br><br>During observation on 2/14/17, at 11:31 a.m. R13 was wheeled out of the dining room in a wheelchair, was alert but not communicative. No | F 329 | continue her on the Lasix for comfort in her respirations. A BMP was ordered, completed and electrolytes were within normal range. Resident #16 receives her Cymbalta for control of her Restless Leg Syndrome. Communication with the physician shows she is at the lowest dose available for this medication. A conference with the physician is scheduled for 3/17/17 to discuss the continued use of this medication.<br><br>Medical records for all other residents were reviewed to determine if routine labs were current as appropriate. All residents receiving psychotropic medications were also reviewed for appropriate diagnosis and evaluation of need for dose reduction. Previous Drug Regimen Reviews for the past 3 months were reviewed to determine if all recommendations have been addressed. A system has been developed to track all Drug Regimen Reviews to insure they have been sent to the physician as appropriate and a reply has been received timely.<br><br>Audits will be completed on 5 residents monthly X 3 months by the Director of Nursing or her designee to determine that necessary labs are being performed, especially as relates to new medications ordered. All residents on psychotropic medications will be reviewed monthly x 6 months by the Director of Nursing, along with the Behavior Committee, to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 329 | Continued From page 24<br>swelling was observed in her extremities.<br><br>During observation on 2/15/17, at 10:09 a.m. R13 was observed lying in bed on her left side, asleep with a regular, non-labored breathing pattern.<br><br>During interview on 2/15/17, at 3:18 p.m. licensed practical nurse (LPN)-A stated R13's last set of electrolyte labs was completed in 11/15, and verified none were on file for the current year or after her Lasix was started in 12/16. LPN-A further stated a stop order was received for lab work on 9/26/16, as R13 had been put on hospice.<br><br>During interview on 2/15/17, at 4:00 p.m. the consultant pharmacist (CP) stated that electrolyte levels should have been done within a couple weeks of beginning R13's Lasix in 12/16. The CP added "If you are going to give a med to treat something that has side effects, you need to monitor for those." The CP further stated he must have missed the lack of electrolyte monitoring at his previous visit.<br><br>The facility policy entitled Unnecessary Medications, dated 9/12 indicated each resident's drug regimen must be free from unnecessary drugs. The definition of an unnecessary drug included those used without adequate monitoring. The policy further identified that the pharmacy, the center and consultant pharmacist are responsible for identifying orders from multiple prescribers and assist in determining the use of unnecessary medications.<br>R16's 2/16/17, diagnosis report included: major depressive disorder, single episode, unspecified.<br><br>R16's current physician orders included an order | F 329 | determine if any dose reductions/evaluations need to be addressed. Results of these audits will be reported at the monthly QAPI meetings and any issues identified will be addressed by the QAPI team as needed. All Drug Regimen Reviews will be audited x 3 months to determine if the new tracking system is working as designed.<br>Completion Date: 3/25/17 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 329 | Continued From page 25 | F 329 | | |

for Cymbalta (antidepressant) 20 milligrams (mg) daily related to depressive disorder not elsewhere classified. The orders indicated R16 had been receiving the same dose of Cymbalta since 9/26/15.

Review of R16's quarterly Minimum Data Set (MDS) dated 2/1/17, identified R16 as receiving an antidepressant and diagnosis of depression. The MDS further indicated R16 had a Patient Health Questionnaire (PHQ-9) score of 8 indicating mild symptoms of depression.

Review of R16's physician notes over the past year did not include an evaluation of R16's prescribed psychoactive medication related to the continued need and use of the Cymbalta.

Review of progress notes over the past year in R16's medical record indicated the pharmacist had made a recommendation on 5/16/16 to taper off the Cymbalta. On 11/17/16, the recommendation was made to consider a dosage reduction or ongoing need for the medication in addition to a review of target behaviors. However, the facility was unable to locate the physician follow up with the 5/16/16, or 11/17/16 recommendations.

During interview on 2/16/17, at 10:53 a.m. director of nursing (DON) stated she was not sure the physician was ever given the recommendations or where the 5/16/16, recommendation was. The DON further indicated the tracking system was "not what it should be" related to pharmacist recommendations and physician response.

The facility's policy titled Medication Regimen

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 329 | Continued From page 26<br>Review revised 11/16, indicates the pharmacist will note drug irregularities or issues of concern for each resident reviewed. Drug irregularities will be reported to the attending physician by the director of nursing services or designee. The location must designate someone to ensure that these reports have been acted upon and documented. | F 329 | | |
| F 371 SS=F | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document | F 371 | F371 FOOD | 3/25/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 371 | Continued From page 27<br>review, the facility failed to serve food in a manner to prevent cross contamination and under sanitary conditions which had the potential to affect all 52 residents who consumed food from the kitchen.<br><br>Findings include:<br><br>On 2/16/17, at 11:05 a.m. the dietary manager (DM) washed hands and applied disposable gloves. After sorting through resident menu slips, the DM started to serve individual plates of food for residents and place them in the service window for staff to deliver.<br><br>At 11:15 a.m. the DM opened the steamer door, grabbed oven mitts and removed the ground beef. The DM then grabbed the thermometer and alcohol wipes to check the temperature. With same gloved hands, the DM continued to serve meals, grabbing menu slips from the serving window which were placed there by staff.<br><br>At 11:30 a.m. the DM removed a pureed shaped corn package from steam table. The packaging was noted to be loose with part of the corn exposed and out of package. DM's gloved hand touched the corn when placed on the plate for service. The empty plastic wrap of the corn was placed on top of the steam table counter. The DM then scooped pureed beef onto the plate. With a sigh, DM then opened a cupboard door, grabbed bowls and set them on the serving area. Using the same gloved hands she scraped the pureed corn and pureed beef from plate into individual bowls using her gloved fingers, removed the gloves and washed her hands.<br><br>At 11:33 a.m. the DM applied disposable gloves | F 371 | PROCURE/STORE/PREPARE/SERVE - SANITARY<br>Food and nutrition staff was educated on how to serve food in a manner to prevent cross contamination and under sanitary conditions for all residents. Food and Nutrition staff was informed of the need to maintain proper gloving technique and infection control. A skills competency in-service has been scheduled for March 22nd and will be conducted by the facility's Registered Dietician Consultant. This in-service will be given to the Dietary Manager and all cooks. Once the Dietary manager is in-serviced and trained, she will in-service the rest of the food and nutrition staff. Additionally, the Dietary manager has been registered for and will attend a refresher ServeSafe course on March 30, 2017.<br><br>The Registered Dietician will audit one meal service per month at her monthly visits for 3 months and the Dietary Manager will also audit one meal service per month for 3 months to ensure that proper gloving is occurring. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 371 | Continued From page 28 | F 371 | | |

and continued to serve resident food. With gloved hands, at 11:38 a.m. the DM opened the steamer door, grabbed oven mitts and removed the ground pork. She checked the temperature and placed the thermometer and alcohol wipes on top of the steam table counter. With the same gloves on, she opened a drawer and removed a serving utensil. The DM continued serving plates of food. At 11:39 a.m. a pureed shaped corn package was noted to be out of packaging in steam table. The DM picked up the pureed corn with her gloved hand and placed on a plate. The thermometer and empty corn packaging fell into the green beans from top of steam table. DM used same gloved hands to remove items from green beans, then pulled up her pants. She then opened a cupboard door and grabbed an insulated plate. The DM pulled up her pants again and started to serve more plates of food wearing the same gloves. At 11:50 a.m. the DM pulled up her pants again, obtained a plate and plate guard from clean dish area and continued to serve food.

On 2/15/17, at 1:43 p.m. the DM confirmed she had touched multiple surfaces without changing gloves or performing hand hygiene but should have done so. The DM verified utensils should have been utilized to scrape food from plate into bowls, pick up pureed shaped corn that had come out of packaging, and remove thermometer and packaging that fell into green beans.

The facility Policy & Procedure titled Sanitation Gloves dated February 2013, instructs that "Gloves are to be changed as follows: a. Before handling "ready to eat" foods. b. When coming in contact with something that is contaminated, such as opening a trash can or touching a doorknob or faucet. c. After sneezing, coughing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 371 | Continued From page 29<br>or touching the face or hair. d. After coming in contact with body fluids." | F 371 | | |
| F 428 SS=D | 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>c) Drug Regimen Review<br><br>(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br><br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic.<br><br>(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br><br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br><br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. | F 428 | | 3/25/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 428 | Continued From page 30<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility consultant pharmacist failed to ensure 1 of 5 residents (R13) reviewed for unnecessary medications received appropriate lab monitoring for a diuretic. In addition, the facility failed to ensure 1 of 5 residents (R16) received timely follow-up of consultant pharmacist suggestions related to the use of an antidepressant.<br><br>Findings include:<br><br>R13's face sheet, dated 2/16/17 identified diagnoses of Parkinson's disease and edema.<br><br>R13's quarterly minimum data set, dated 12/14/16 identified a terminal prognosis, and identified R13 was non-verbal and totally dependent on staff for cares. A care area assessment (CAA) for dehydration/fluid maintenance was not triggered.<br><br>R13's physician's orders, dated 2/16/17 identified | F 428 | F428 DRUG REGIMEN REVIEW<br>The physician for Resident #13 was contacted and the decision was made to continue her on the Lasix for comfort in her respirations. A BMP was ordered, completed and electrolytes were within normal range. Resident #16 receives her Cymbalta for control of her Restless Leg Syndrome. Communication with the physician shows she is at the lowest dose available for this medication. A conference with the physician is scheduled for 3/17/17 to discuss the continued use of this medication.<br><br>Medical records for all other residents were reviewed to determine if routine labs were current as appropriate. All residents receiving psychotropic medications were also reviewed for appropriate diagnosis and evaluation of need for dose reduction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 428 | Continued From page 31<br>an order for Lasix (a diuretic used to control fluid balance that can significantly deplete potassium levels in the blood) 40 milligrams (mg) daily for edema, with a start date of 12/23/16. No routine lab work was ordered to monitor R13's electrolytes and no potassium supplement was ordered.<br><br>R13's medication administration record, dated 2/17 identified R13 was still receiving the Lasix on a daily basis.<br><br>A review of R13's chart did not reveal any electrolyte labs being drawn within the previous 12 months.<br><br>R13's consultant pharmacy reviews did not reveal the lack of electrolyte monitoring had been identified.<br><br>During interview on 2/15/17, at 3:18 p.m. licensed practical nurse (LPN)-A stated R13's last set of electrolyte labs was completed in 11/15, and verified none were on file for the current year or after her Lasix was started in 12/16. LPN-A further stated a stop order was received for lab work on 9/26/16, as R13 had been put on hospice.<br><br>During interview on 2/15/17, at 4:00 p.m. the consultant pharmacist (CP) stated that electrolytes levels should have been done within a couple weeks of beginning R13's Lasix in 12/16 and added "If you are going to give a med to treat something that has side effects, you need to monitor for those." The CP further stated he must have missed the lack of electrolyte monitoring at his previous visit. | F 428 | Previous Drug Regimen<br>Reviews for the past 3 months were reviewed to determine if all recommendations have been addressed. A system has been developed to track all Drug Regimen Reviews to insure they have been sent to the physician as appropriate and a reply has been received timely.<br><br>Audits will be completed on 5 residents monthly X 3 months by the Director of Nursing or her designee to determine that necessary labs are being performed, especially as relates to new medications ordered. All residents on psychotropic medications will be reviewed monthly x 6 months by the Director of Nursing, along with the Behavior Committee, to determine if any dose reductions/evaluations need to be addressed. Results of these audits will be reported at the monthly QAPI meetings and any issues identified will be addressed by the QAPI team as needed. All Drug Regimen Reviews will be audited x 3 months to determine if the new tracking system is working as designed.<br>Completion Date: 3/25/17 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 428 | Continued From page 32 | F 428 | | |

A Mountain Lake GS (Good Samaritan) Village Drug Regimen Review Report was subsequently faxed to the facility and was dated 2/15/17, with the time faxed listed as 6:07 p.m. The drug regimen review report indicated electrolyte monitoring should occur if Lasix is to be continued, and indicated the CP had received a call from health department survey staff concerning hospice/Lasix order monitoring.

The facility policy entitled Unnecessary Medications, dated 9/12, indicated each resident's drug regimen must be free from unnecessary drugs. The definition of an unnecessary drug included those used without adequate monitoring. The policy further identified that the pharmacy, the center and consultant pharmacist are responsible for identifying orders from multiple prescriber's and assist in determining the use of unnecessary medications.

R16's diagnosis report dated 2/16/17, included: major depressive disorder, single episode, unspecified.

R16's current physician orders included an order for Cymbalta (antidepressant) 20 milligrams (mg) daily related to depressive disorder not elsewhere classified. The orders indicated R16 had been receiving the same dose of Cymbalta since 9/26/15.

Review of R16's quarterly Minimum Data Set (MDS) dated 2/1/17, identified R16 as receiving an antidepressant and diagnosis of depression. The MDS further indicated R16 had a Patient Health Questionnaire (PHQ-9) score of 8 indicating mild symptoms of depression.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 428 | Continued From page 33 | F 428 | | |

Review of R16's physician notes over the past year did not include an evaluation of R16's prescribed psychoactive medication related to the continued need and use of the Cymbalta.

Review of progress notes over the past year in R16's medical record indicated the pharmacist had made a recommendation on 5/16/16 to taper off the Cymbalta. On 11/17/16, the recommendation was made to consider a dosage reduction or ongoing need for the medication in addition to a review of target behaviors. However, the facility was unable to locate the physician follow up with the 5/16/16, or 11/17/16 recommendations.

During interview on 2/16/17, at 10:53 a.m. director of nursing (DON) stated she was not sure the physician was ever given the recommendations or where the 5/16/16 recommendation was at. The DON further indicated the tracking system was "not what it should be" in reference to the pharmacists recommendations and physician response.

The consultant pharmacist supplied a copy of 5/16/16 recommendation where it was suggested to taper off the Cymbalta. The 11/17/16, recommendation also suggested to discontinue the Cymbalta if not effective/no longer needed or review the indication for continuing the medication. Neither recommendation had a response from the physician.

Interview with the facility's consulting pharmacist (CP) on 2/16/17, at 11:37 a.m. indicated he would expect his recommendation be addressed with the physician by the facility. The CP stated if over a 2 month cycle no response was received he

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING _____ B. WING _____ | 02/16/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 428 | Continued From page 34<br>would recommend and write a "second comment" recommendation on next visit. The CP verified no recommendations had been created with review of R16's record since 11/17/16. | F 428 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/14/2017** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101-5145, or | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/17/2017 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/14/2017** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | Continued From page 1<br>By email to:<br>Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us><br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Building 01 of Good Samaritan Society Mountain Lake was constructed as follows:<br>The original building was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction;<br>The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction;<br>The 2000 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction.<br>The 2013 link addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. There are no resident sleeping or treatment areas located in this addition. This addition is separated from an assisted living facility by a proper two-hour fire wall assembly. | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/14/2017** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | Continued From page 2<br>These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.<br><br>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 52 at time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 133 SS=E | NFPA 101 Multiple Occupancies - Construction Type<br><br>Multiple Occupancies - Construction Type<br>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:<br>* 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<br>* 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<br>This STANDARD is not met as evidenced by:<br>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 | After finding the doors that connect the skilled nursing facility and the assisted living facility did not close properly, the | 2/15/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/14/2017** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 133 | Continued From page 3<br>could affect 52 out of 52 residents.<br><br>Multiple Occupancies - Construction Type<br>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:<br>* 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<br>* 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<br><br>FINDINGS INCLUDE:<br><br>On facility tour between 12:00 PM and 3:00 PM on 02/14/2017, observation revealed the doors in the 2 hour fire separation wall between Good Samaritan Society, Mountain Lake and the Assisted Living Facility failed to close and positively latch into the door frame.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 133 | closures on both doors were adjusted. This was fixed on 2/15/2017 and the doors now close and latch properly and therefore maintain the 2-hour fire separation. | |
| K 291 SS=D | NFPA 101 Emergency Lighting<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. | K 291 | | 2/20/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/14/2017** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 291 | Continued From page 4<br>18.2.9.1, 19.2.9.1<br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the Facility failed to maintain emergency lighting in accordance with 7.9. The deficient practice could affect 52 out of 52 residents.<br><br>Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1<br><br>FINDINGS INCLUDE:<br><br>On facility tour between 12:00 PM and 3:00 PM on 02/14/2017, observation revealed the emergency light on the west wall of the generator room was tested and found to be not functioning.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 291 | The emergency light located on the interior west wall of the generator shed was found to be inoperable. The light fixture was replaced with a new one on 2/20/2017 and is fully functioning. | |
| K 300 SS=F | NFPA 101 Protection - Other<br><br>Protection - Other<br>List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and interview, the Facility failed to maintain complete documentation on the Annual Fire/Smoke Door | K 300 | There was not any documentation for an annual fire and smoke door inspection. Beginning 2/21/2017 we have | 2/21/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/14/2017** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 300 | Continued From page 5<br>Inspection per NFPA 80. The deficient practice could affect 52 out of 52 residents.<br><br>Protection - Other<br>List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br><br>FINDINGS INCLUDE:<br><br>On facility tour between 12:00 PM and 3:00 PM on 02/14/2017, documentation reviewed revealed that not all the required information is being documented during the Annual Fire and Smoke Door Inspection per the NFPA 80.<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 300 | implemented a set of forms to do this inspection from this time forward. | |
| K 918 SS=E | NFPA 101 Electrical Systems - Essential Electric Syste<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 | K 918 | | 2/21/17 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/14/2017** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 918 | Continued From page 6<br>months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This STANDARD is not met as evidenced by:<br>Based on documentation review and interview, the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This deficient practice could affect 52 of 52 residents.<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 | K 918 | The forms currently used for documenting the emergency generator test were found to be lacking some information. On 2/21/2017 we switched the forms we had been using to a form that includes the information (transfer time and cool down time) required by the fire marshal. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245549 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/14/2017** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 918 | Continued From page 7<br>day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br><br>FINDINGS INCLUDE:<br><br>On facility tour between 12:00 PM and 3:00 PM on 02/14/2017, documentation reviewed revealed that not all the required information is being documented during the Month Emergency Generator Load Test.The transfer time of how long it takes the emergency generator to assume power and the cool down time after the 30 minute monthly load test is not being recorded.<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 918 | | |