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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PK3S
Facility ID: 00962

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245294**

2. STATE VENDOR OR MEDICAID NO. (L2) **300021400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WATERVILLE**
(L4) **205 FIRST STREET NORTH**
(L5) **WATERVILLE, MN** (L6) **56096**

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 **08/27/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

12. Total Facility Beds **33** (L18)

13. Total Certified Beds **33** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	33			
(L37)	(L38)	(L39)	(L42)	(L43)

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

See attached.

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 10/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **06/01/1986** (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. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/28/2014** (L33)

DETERMINATION APPROVAL

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

CCN 24-5294

A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 7/30/14 following a Minnesota Department of Health survey on 7/8/14. At this Comparative Federal Monitoring Survey, Good Samaritan Society - Waterville was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Refer to CMS form 2567B. Documentation supporting the facility's request for a continuing waiver involving K67 has been forwarded. Approval of the waiver request has been approved.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245294

October 17, 2014

Ms. Katie Davis, Administrator
Good Samaritan Society - Waterville
205 First Street North
Waterville, Minnesota 56096

Dear Ms. Davis:

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

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

Effective September 26, 2014 the above facility is certified for:

33 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 33 skilled nursing facility bed.

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

Your request for waiver of K67 has been approved based on the submitted documentation.

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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

October 17, 2014

Ms. Katie Davis, Administrator
Good Samaritan Society - Waterville
205 First Street North
Waterville, Minnesota 56096

RE: Project Number S5294023, FMS Project F5294022

Dear Ms. Davis:

On July 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 30, 2014 a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. On August 13, 2014, CMS forwarded the results of the LSC FMS and notified you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

> Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 10, 2014 (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of August 13, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 10, 2014.

On August 27, 2014 the Minnesota Department of Health completed a Post Certification Revisit (PCR) and On October 7, 2014 the Minnesota Department of Public Safety completed a PCR of your facility to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 10, 2014 and the FMS Survey completed on July 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 10, 2014 and the FMS Survey completed on July 30, 2014, effective September 26, 2014.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the remedy outlined in their letter of August 13, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 10, 2014 be rescinded. (42 CFR 488.417(b)).

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 10, 2014 is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 10, 2014, is to be rescinded.

In the CMS letter of August 13, 2014, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 10. 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the July 10, 2014 standard survey has been Approved by CMS.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112   Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245294	A. Building B. Wing **01 - MAIN BUILDING 01**	10/7/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WATERVILLE	205 FIRST STREET NORTH WATERVILLE, MN 56096

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0017	**09/19/2014**	ID Prefix Reg. # **NFPA 101** LSC K0022	**09/19/2014**	ID Prefix Reg. # **NFPA 101** LSC K0025	**09/19/2014**
ID Prefix Reg. # **NFPA 101** LSC K0027	**09/19/2014**	ID Prefix Reg. # **NFPA 101** LSC K0029	**09/19/2014**	ID Prefix Reg. # **NFPA 101** LSC K0038	**09/19/2014**
ID Prefix Reg. # **NFPA 101** LSC K0045	**09/19/2014**	ID Prefix Reg. # **NFPA 101** LSC K0048	**09/19/2014**	ID Prefix Reg. # **NFPA 101** LSC K0052	**09/19/2014**
ID Prefix Reg. # **NFPA 101** LSC K0075	**09/26/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KFD	10/17/2014	25822	10/07/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/30/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245294	A. Building B. Wing	8/27/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WATERVILLE	205 FIRST STREET NORTH WATERVILLE, MN 56096

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0221 Reg. # 483.13(a) LSC	08/19/2014	ID Prefix F0272 Reg. # 483.20(b)(1) LSC	08/19/2014	ID Prefix F0276 Reg. # 483.20(c) LSC	08/19/2014
ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	08/19/2014	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	08/19/2014	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	08/19/2014
ID Prefix F0314 Reg. # 483.25(c) LSC	08/19/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	10/17/2014	28591	08/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/10/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245294	A. Building B. Wing 01 - MAIN BUILDING 01	10/7/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WATERVILLE	205 FIRST STREET NORTH WATERVILLE, MN 56096

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 08/21/2014	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 08/21/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KFD	10/17/2014	25822	10/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
7/8/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Protecting, Maintaining and Improving the Health of Minnesotans

October 17, 2014

Ms. Katie Davis, Administrator
Good Samaritan Society - Waterville
205 First Street North
Waterville, Minnesota 56096

Re: Enclosed Reinspection Results - Project Number S5294023

Dear Ms. Davis:

On August 27, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 10, 2014, , with orders received by you on August 1, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

AH Form Approved
10/17/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00962	A. Building B. Wing	8/27/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WATERVILLE	205 FIRST STREET NORTH WATERVILLE, MN 56096

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20505** Reg. # **MN Rule 4658.0300 Subp.** LSC	Correction Completed **08/19/2014**	ID Prefix **20550** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **08/19/2014**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **08/19/2014**
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **08/19/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/KFD	10/17/2014	28591	08/27/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/10/2014

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PK3S
Facility ID: 00962

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245294**

2. STATE VENDOR OR MEDICAID NO. (L2) **300021400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WATERVILLE**
(L4) **205 FIRST STREET NORTH**
(L5) **WATERVILLE, MN** (L6) **56096**

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 **07/10/2014** (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 **33** (L18)

13.Total Certified Beds **33** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	33			
(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 :
Kathy Hahn, HFE NE II 08/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/25/2014 (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
06/01/1986
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 2130

July 28, 2014

Ms. Katie Davis, Administrator
Good Samaritan Society - Waterville
205 First Street North
Waterville, Minnesota 56096

RE: Project Number S5294023

Dear Ms. Davis:

On July 10, 2014, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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;

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

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

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

DEPARTMENT CONTACT

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

Kathyrn Serie, Unit Supervisor
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529
Telephone: (507) 537-7158
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 19, 2014, 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 August 19, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 10, 2014 (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 January 10, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an

informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118   Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

5294s14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245294	A. BUILDING ______ B. WING ______	07/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WATERVILLE	205 FIRST STREET NORTH WATERVILLE, MN 56096

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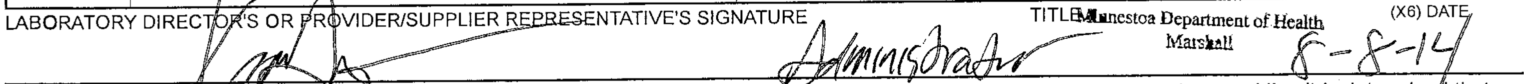
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	F221 Plan of Correction: Resident # 22 nursing staff on duty were immediately re-educated on restraint use, when to apply and remove per facility policy and procedure.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to utilize a physical restraint for 1 of 1 resident (R22) in a manner where the least restrictive device was utilized for the least amount of time. Findings include: R22 was admitted with diagnoses identified on the care plan that included: dementia, Parkinson's, anxiety, congestive heart failure and back pain. R22's medical record identified R22 had sustained multiple falls in the past year. The falls	F 221 approved KMT 8/11/14	All residents were reviewed and none were identified as using a restraint. Nursing staff education was/will be provided by Staff Development on 8/19 date regarding the facility's policy and procedure for restraint use. Audits for Resident #22 and random other residents will be conducted by the DNS or designee for residents with restraints weekly X 4, monthly X 3. Audit results will be referred to the Quality Committee for further recommendations. RECEIVED AUG 10 2014	8-19-14



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Administrator — (X6) DATE 8-8-14

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

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F 221	Continued From page 1 were associated with leaning in chair or attempts to self transfer from one surface to the next surface. On 6/10/14, a Lap Buddy (device restricting freedom of movement from her chair) was implemented as an intervention to reduce R22's risk of falling. A Physical Restraint Assessment, dated 6/10/14, identified that R22 required the use of a Lap Buddy related to sustaining six (6) falls in the past 2 months, had diagnoses of Parkinson's disease and dementia, displayed rigidity, instability and shakiness. The assessment also identified that R22 was unable to independently remove the Lap Buddy. During cares on 7/9/14, at 1:44 p.m. R22 was observed leaning forward while seated in the wheelchair in the dining room. R22 was observed to lean over and wipe the floor with a napkin. It was noted the Lap Buddy had not been attached between the arms of the wheelchair. At 1:47 p.m. trained medication assistant (TMA)-A was observed to retrieve R22's Lap Buddy and was overheard explaining that the TMA-A was going to place the device in her wheelchair if R22 was going to wipe the floor. The Lap Buddy was then applied. On 7/9/14, at 1:48 p.m. the activity director noted R22 continued to lean forward in her wheelchair (Lap Buddy applied) and asked R22 if she would like to play Bingo. R22 was wheeled to a dining room table that had residents and staff seated. At 2:00 p.m. R22 was observed to be seated at the dining room table in an upright position playing Bingo. Staff were seated at the table alongside R22 and the Lap Buddy was attached between the arm rests of the wheelchair. At 2:33	F 221		

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F 221	Continued From page 2 p.m. it was observed that although R22 remained seated at the dining room table with staff present, the Lap Buddy remained in the wheelchair as she played Bing. On 7/9/14, at 2:45 p.m. the director of nurses (DON) was interviewed and verified R22's Lap Buddy should have been removed while seated at the table with staff. The DNS stated staff were instructed to remove the Lap Buddy at times when staff are in close proximity. The facility policy for restraint use titled, Physical Restraints revised 8/2008, identified the following guidance in section 3: (a.) Restraints must be released at least every two hours. Check for any areas of irritation, reposition the resident allow the resident to exercise or an opportunity to move. (b.) Observe restrained residents. Frequency of this observation is determined by the care plan team. (c.) The interdisciplinary team or reduction committee must continually monitor and evaluate the utilization of the restraint and pursue the least restrictive device with a goal to utilize alternatives whenever possible (such as close observation during a small group event or during meal times that may preclude the use of the restraint).	F 221		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.	F 276	F276 R22 – A comprehensive assessment was completed for R22 on 8/8 and care plan was updated as appropriate. All residents with pressure ulcers were reviewed to ensure comprehensive assessments and care planning is appropriate and in place. All nursing staff will be provided with re-education on the facilities policies and procedures for pressure ulcer	8-19-14

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F 276	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a pressure ulcer was comprehensively assessed so that interventions could be implemented to maintain skin integrity for 1 of 3 residents (R9) reviewed for pressure ulcers. Findings include: R9 was admitted on 1/10/05 with a diagnoses that included a pressure ulcer on the coccyx, right hip and right buttocks, multiple sclerosis and paraplegia/quadriplegia. Review of the most current quarterly Minimum Data Set (MDS) dated 6/12/14 , identified R9 as alert and oriented with no behavioral issues. The MDS indicated the resident has one (1) stage 3 pressure ulcer, two (2) stage 4 pressure ulcers that were present on admission and one (1) unstageable pressure ulcer that occurred after admission. The MDS further indicated R9 required extensive assistance of staff with bed mobility, which included repositioning. Review of the current Braden scale dated 6/10/14, identified R9 as high risk for pressure sores. Further review of the record lacked evidence that any further assessments had been conducted to prevent/address the integrity of the pressure ulcers and the development of the unstageable pressure ulcer that was identified on 2/14/14. Review of the weekly wound documentation dated 2/14/14, identified R9 as having a new unstageable pressure ulcer to the right heel. The documentation indicated the pressure ulcer was 100% eschar. A copa treatment dressing was	F 276	prevention and management by 8/19 by the DNS or designee. Audits will conducted for R#22 and random other residents weekly X 4, monthly X 3 to ensure comprehensive assessments and interventions are in place to maintain skin integrity. These results will be taken to Quality Meeting for further recommendations.	

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F 276	Continued From page 4 ordered and documented measurements were: 4.8 cm length by 5.0 cm width. No assessment of the pressure ulcer was evident in the medical record related to possible causal factors related to the right heel ulcer. During interview with the DON on 7/10/14 at 9:30 a.m. confirmed the above findings.	F 276		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278	F278 R42's MDS dated 6/16/2014 will be amended to accurately reflect the findings on the positioning data collection tool by 8/19. All residents with pressure ulcers were reviewed to ensure their MDSs have been coded accurately. All were found to be accurate. Re-education was provided to the MDS coordinators regarding accurate coding of the MDS on 8-12-2014. All MDSs of residents with pressure ulcers will be audited weekly X 4, Monthly X 3 to ensure accurate coding. The results will be taken to Quality Meeting for further recommendations.	8-19-14

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F 278	Continued From page 5 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accurately code the Minimum Data Set (MDS) assessment related to pressure ulcers for 1 of 1 residents (R42) in the closed record sample reviewed for pressure ulcers. Findings include: R42 was admitted on 6/2/14. The 14 day initial Minimum Data Set (MDS) dated 6/16/14, identified R42 as being at risk for pressure ulcers, but currently did not have any pressure ulcer. However, review of the initial admission data collection tool dated 6/2/14, it identified that R42 had a reddened buttock. A positioning data collection tool indicated the resident had redness of the coccyx area on 6/7/14 and 6/10/14 after 2 hours of pressure when lying in bed. Although, the assessments identified R42 as having a stage 1 (persistent redness) pressure area to the coccyx, the MDS did not accurately reflect this.	F 278		

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F 278	Continued From page 6 Interview with the director of nursing (DON) on 6/8/14, at 1:00 p.m. confirmed R42 was identified as having a stage 1 pressure ulcer on the admission skin audits but the MDS did not accurately reflect the data from the positioning data collection tool.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a care plan which included the appropriate use and length of time a Lap Buddy was to be utilized for 1 of 1	F 279	F279 R#22's care plan was updated on 8-8-14 to reflect when and why the restraint should be used and when it should be	8-19-14

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F 279	Continued From page 7 resident (R22) reviewed who had a Lap Buddy applied to the wheelchair daily. Findings include: R22 was admitted with diagnoses identified on the care plan that included: dementia, Parkinson's disease, anxiety, congestive heart failure (CHF) and back pain. Review of the medical record identified that R22 had sustained multiple falls in the past year. The falls were associated with R22 leaning forward in the wheelchair and/or attempted to self transfer from one surface to the next surface. On 6/10/14, a Lap Buddy (device restricting freedom from movement from her chair) was implemented as an intervention to reduce R22's risk of falling. A Physical Restraint Assessment, dated 6/10/14, identified that R22 required the use of a Lap Buddy related to sustaining six (6) falls in the past 2 months, had diagnoses of Parkinson's disease and dementia, displayed rigidity, instability and shakiness. The assessment also identified that R22 was unable to independently remove the Lap Buddy. During observation on 7/9/14, at 1:44 p.m. R22 was observed leaning forward while seated in the wheelchair in the dining room. R22 was observed to lean over and wipe the floor with a napkin. It was noted the Lap Buddy had not been attached between the arms of the wheelchair. At 1:47 p.m. trained medication assistant (TMA)-A was observed to retrieve R22's Lap Buddy and was overheard explaining that the TMA-A was going to place the device in her wheelchair if R22 was going to wipe the floor. The Lap Buddy was then	F 279	removed. Staff caring for this resident were immediately re-educated on these interventions at the time of the survey. No other residents have been identified as using restraints. All nurses will be provided with re-education regarding the facilities policy and procedures for developing and implementing care planned interventions for restraint use on 8/19. Audits will be conducted for R22 and any other residents with restraints (should there be any) to ensure restraints are care planned appropriately. These audits will be done weekly X 4, Monthly X 3 and then taken to Quality Meeting for further recommendations.	

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F 279	Continued From page 8 applied. On 7/9/14, at 1:48 p.m. the activity director noted R22 continued to lean forward in her wheelchair and asked R22 if she would like to play Bingo. R22 was wheeled to a dining room table that had residents and staff seated. At 2:00 p.m. R22 was observed to be seated at the dining room table in an upright position playing Bingo. Staff were seated at the table alongside R22 and the Lap Buddy was attached between the arm rests of the wheelchair. At 2:33 p.m. it was observed that although R22 remained seated at the dining room table with staff present, the Lap Buddy remained in the wheelchair as she played Bing. On 7/9/14, at 2:45 p.m. the director of nurses (DON) was interviewed and verified R22's Lap Buddy should have been removed while seated at the table with staff. The DNS stated staff were instructed to remove the Lap Buddy at times when staff are in close proximity. During review of R22's care plan, dated 6/10/14, it was noted that although the Lap Buddy had been identified as a device utilized for R22, it lacked interventions related to the appropriate use of the Lap Buddy and the length of time the device should be applied to the wheelchair. The care plan lacked clear parameters to identify when staff should utilize the device.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	F281 R42 –no longer resides in center. All residents identified as high risk for pressure ulcers have been reviewed for comprehensive assessments and appropriate care planning. This will be completed by 8/19 Re-education has been provided to all nursess on facility policy and procedures for Pressure Ulcer identification, prevention, comprehensive assessment,	8-19-14

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F 281	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record interview and document review the facility failed to implement a short term care plan, which included immediate interventions, after an initial assessment identified a stage 1 pressure ulcer for 1 of 1 resident (R42) in the closed record sample reviewed who had a pressure ulcer. Findings include: R42 was admitted on 6/2/14. The 14 day initial Minimum Data Set (MDS) dated 6/16/14, identified R42 as being at risk for pressure ulcers, but currently did not have any pressure ulcer. Review of the initial admission data collection tool dated 6/2/14, identified R42 as having a reddened buttock. A positioning data collection tool indicated R42 had redness of the coccyx area on 6/7/14 and 6/10/14 after two (2) hours of of pressure when lying in bed. The positioning assessment and evaluation form dated 6/10/14, indicated the resident had a reddened coccyx and his skin turgor was poor. It further included that R42 should be repositioned every two hours and to relieve pressure from the coccyx. Review of the short term care plan dated 6/2/14, indicated R9 had alteration in skin integrity related to immobility. The care plan did not address nor include interventions related to the reddened area on the coccyx that was identified upon admission and failed to identify a repositioning schedule. Interview with the director of nursing (DON) on 7/8/14, at 1:00 p.m. confirmed the short term care plan for R42 did not include interventions related	F 281	and care planning by 8/19. All nurses have been provided with re-education on completing data collection tools for positioning and communicating any identified skin issues to the RN timely. Audits will be conducted for random residents identified to be at high risk for pressure ulcers weekly X 4, Monthly X 3 to ensure assessments and care planning are in place and appropriate. Results will be taken to Quality Meeting for further recommendations.	

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F 281	Continued From page 10 to the stage 1 pressure ulcer noted when initial data collection had completed.	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement assessment and interventions to maintain skin integrity for 1 of 2 residents (R9) reviewed who had multiple pressure ulcers and developed an unstageable pressure ulcer to the right heel; and for 1 of 1 resident (R42) reviewed in a closed record who had a stage 1 pressure ulcer. The facility's failure to adequately assess and implement interventions resulted in actual harm for R9. Findings include: R9 had been admitted to the facility on 1/10/05, with diagnoses including pressure ulcers on the coccyx, right hip and right buttocks; multiple sclerosis and paraplegia/quadriplegia. R9 has a history of chronic smoking. During observation of R9's positioning on 7/9/14,	F 314	F314 R42 – is no longer residing in the center. R9 – A comprehensive assessment was completed on 8/8/14 and the care plan has been updated appropriately. All residents identified as high risk for pressure ulcers have been reviewed for comprehensive assessments and appropriate care planning. This will be completed by 8/19 Re-education has been provided to all nursing staff on facility policy and procedures for Pressure Ulcer identification, prevention, comprehensive assessment, care planning. Re-education will be provided on expectation of and importance of following care planned interventions and appropriate documentation of	8-19-14

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F 314	Continued From page 11 at 8:00 a.m. it was noted the resident was lying on her right side in bed. R9 was observed to be transferred into the chair at 10:15 a.m. with a heel lift round wedge applied to her right lower leg. R9 was observed to remain seated in her wheelchair without repositioning until 12:45 p.m. (2 1/2 hours) when she was transferred back into bed. There was no observations that staff offered R9 repositioning during this time. Review of the weekly wound documentation dated 2/14/14, identified R9 as having a new unstageable pressure ulcer to the right heel. The documentation indicated the pressure ulcer was 100% eschar and a treatment dressing was ordered. Measurements at the time were documented as 4.8 cm (centimeters) length by 5.0 cm width. Review of R9's record revealed there had been no documented assessment of the pressure ulcer including assessment of causal factors and/or interventions. Review of the quarterly Minimum Data Set (MDS) assessment dated 6/12/14 , identified R9 as alert and oriented with no behavioral issues. The MDS indicated the resident had one stage 3 pressure ulcer; two stage 4 pressure ulcers that were present on admission; and one unstageable pressure ulcer that had developed after admission (2/14/14). The 6/12/14 MDS further indicated R9 required extensive assistance of staff with bed mobility, including repositioning. Review of a Braden scale assessment for pressure ulcer risk dated 6/10/14, identified R9 as being at high risk for pressure sore development and identified interventions to prevent pressure ulcer as including: planned turning schedule, supplement with small shift positions, pressure	F 314	resident refusal of care and risk benefit discussions with residents and families. This education will be completed by DNS/Staff Development Coordinator by 8/19 date. R9 and random other residents identified to be at high risk for pressure ulcers will be audited to ensure appropriate assessments and care planning are in place and interventions are being followed as care planned. These audits will be done weekly X 4, monthly X 3 with results presented to Quality Meeting for further recommendations.	

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F 314	Continued From page 12 reduction support, maximal remobilization and heel protection. Review of the resident's most current care plan dated 4/29/14, identified R9 as having alteration in mobility related to (R/T) spastic quadriplegia with no voluntary movement in upper and lower extremities. The plan and interventions included: (1) total assistance with bed mobility which includes turning and repositioning every 2 hours, (2) measure pressure ulcers weekly and (3) staff to monitor skin and report any changes to the physician. The care plan further indicated R9 had alteration in skin integrity related to immobility and pressure ulcers. The planned interventions include: (1) reposition every 2 hours and as the resident allows, resident refuses repositioning in her wheelchair, (2) weekly skin checks and (3) provide treatment as ordered. Although, the care plan indicated R9 refuses repositioning while seated in her wheelchair, the care plan did not identify approaches/concerns related to the refusals of care/repositioning. Interview with the director of nursing (DON) on 7/9/14, at 11:00 a.m. indicated R9's plan of care instructed the staff to allow R9 to request when she desires to be repositioned when seated in her chair. The DON revealed that in the past she recalled R9 disliking to be repositioned/off-loaded when seated in her wheelchair, but could not recall when this occurred. She indicated R9 felt it was too uncomfortable to get repositioned again back in her chair. However, this had not been identified on the care plan. During interview with R9 and her mother on 7/9/14, at 12:00 p.m. R9's mother stated she attends care conference routinely. She had not	F 314		

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F 314	Continued From page 13 recalled discussions in the past couple of years related to refusals of repositioning. She indicated that a few years ago, she recalled on occasion the resident refused repositioning when in bed, but had no recollection of discussions related to her refusals when in the wheelchair. R9 was interviewed further on 7/9/14 at 12:15 p.m., related to her repositioning schedule. R9 stated she was usually ready to lay down after 2 hours, but that she waits for the staff because they are busy assisting with dinner in the dining room and she does not want to bother them. When questioned whether she was aware of the risks of being seated too long in the wheelchair, she responded that she had been made aware. R9 further included that she rarely calls for assistance when up in the wheelchair but waits for staff to come and reposition her. She indicated she does not refuse to be laid down when given the opportunity from staff. During interview with nursing assistants (NA)-C and NA-D on 7/10/14, at 7:30 a.m. who had provided care several years for R9, they both indicated they follow the care plan related to R9 repositioning program. NA-C and NA-D indicated the care plan directs staff to reposition the resident every 2 (two) hours while in bed. NA-C and NA-D further included that when R9 is positioned in the wheelchair, the care plan indicates R9 will request assistance when she wants to be repositioned. NA-C stated she recently [couple days ago] asked R9 to be repositioned while in her wheelchair and R9 did not refuse the offer. NA-C stated that she had been told in the past R9 did not like to be repositioned (off-loading) while seated in the wheelchair because of the difficulty to reposition	F 314		

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F 314	Continued From page 14 R9 again. NA-C stated the resident did not mind being laid down in bed after positioned in the wheelchair and a position change was required to maintain skin integrity. Neither NA-C or NA-D recalled a time when R9 had refused repositioning when seated in the chair. During review of the interdisciplinary team progress notes (IDT) there had been two entries documented since 10/14/10, regarding R9's refusal to be repositioned: 1) "10/14/10, 1500 (3:00 p.m.), Resident has been refusing 10:00 p.m. repositioning. Explained the benefits and risk and she understands this, she feels she is being repositioned because the HOB (head of bed) is elevated from 8:00 p.m. to 10:00 p.m. and then lays flat at 10:00 p.m." and 2) IDT (interdisciplinary team) notes dated 2/19/13 at 7:15 a.m., "late entry 2/18/13 at 1345 (1:45 p.m.) I don't like my side, writer explained to resident that she needs to get off her buttock, 'I don't care. I know what can happen and I don't want to be on my side.' Writer repositioned [R9] her on her back. Both entries were documented by the same registered nurse (RN). No other entries related to refusals of repositioning were documented in the medical record. Both entries were related to repositioning when in bed and not related to repositioning when seated in her wheelchair as the care plan indicated. During interview with the DON and the administrator on 7/10/14, at 9:30 a.m. they confirmed they were unable to provide further documentation related to resident refusals of repositioning in the past or that the risks were reviewed/revised with the resident other than the 2 entries in the nurses notes dated 10/14/10 (3 1/2 + yrs. ago) and 2/18/13 (1 yr. 4 months ago)	F 314		

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F 314	Continued From page 15 relative to repositioning in bed. Observations were made of R9's pressure ulcers on 7/10/14, at 11:45 a.m. with licensed practical nurse (LPN)-A. The following was noted: (1) The right heel pressure ulcer was observed to be pink with dry skin around the ulcer. LPN-A measured the wound to be 0.7 cm length, by 0.5 cm width and 0.8 cm depth. No drainage was noted; (2) The pressure ulcer on the right ischium was pinkish in color and slightly reddened with a small amount of whitish drainage on the dressing; (3) The pressure ulcer on the coccyx was pinkish in color with redness noted around the ulcer but no drainage noted; and (4) The left trochanter was noted to be pinkish with slight redness around the ulcer and no drainage was noted. During review of the weekly wound documentation dated January 2014 thru July 2014, it was noted that a new pressure ulcer developed on the right heel that was unstageable. The documentation revealed the pressure ulcer located on the left trochanter had slightly increased and the pressure ulcer described as #1 had healed and then reoccurred. The pressure ulcers located on the right heel, right ischium and coccyx #2 remained fairly stable, without an increase in size. The identified pressure ulcers were documented as noted: Right heel measurements: 02/2/14 length 4.8 centimeters (cm), width 5.0 cm, unstageable 3/18/14 length 2.5. cm, width 1.8 cm, no depth 4/18/14 length 2.5 cm, width 2.5 cm, no depth	F 314		

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F 314	Continued From page 16 5/19/14 length 2.0 cm, width 2.0 cm, depth 0.3 cm 06/6/14 length 0.7 cm, width 0.6, depth 0.2 cm 7/10/14 length 0.7 cm, width 0.5 cm, depth 0.8 cm Right ischium measurements: 1/14/14- length 4.0 cm, width 10 cm, depth 5.2 cm 2/14/14- length 5.0 cm, width 9.0 cm, depth 4.5 cm 3/17/14- length 4.5, width 10 cm, depth 5.4 cm 4/18/14- length 5.0 cm, 10.2 cm, depth 3.3 cm 5/19/14- length 6.0 cm, width 10 cm, depth 5.2 cm 6/19/14- length 6.6 cm, width 9.4 cm, depth 4.4 cm Coccyx #1 measurements: 1/14/14- length 0.3 cm, width 0.1 cm, no depth 2/14/14-healed 3/17/14-length 1.2 cm, width 1 cm, depth 0.4 cm 4/18/14-length 0.9 cm, width 0.3 cm, no depth 5/19/14-length 0.5 cm, width 0.7 cm, no depth Coccyx #2 measurements: 1/14/14-length 2.5 cm, width 2.0 cm, no depth 2/14/14-length 2 cm, width 2.0 cm, no depth 3/17/14-length 2 cm, width 0.2 cm, depth 0.1 cm 4/18/14-length 0.8 cm, width 1.2 cm, depth 0.3 cm 5/19/14-length 0.25 cm, width 0.25 cm, no depth Left Trochanter measurements: 1/14/14-length 0.5 cm, width 0.1 cm, depth 2.2 cm 2/14/14-length 0.5 cm, width 0.1 cm, depth 3.0 cm 3/17/14-length 0.5 cm, width 0.2 cm, depth 2.8	F 314		

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F 314	Continued From page 17 cm 4/18/14-length 0.5 cm, width 0.2 cm, depth 5.0 cm 5/19/14-length 0.5 cm, width 0.2 cm, depth 3.9 cm 6/13/14-length 0.5 cm, width 0.3 cm, depth 2.7 cm R42 was admitted on 6/2/14 with diagnosis that included; lung cancer with metastasis to the brain and malnutrition. Review of the admission 14 day Minimum Data Set (MDS) dated 6/16/14, identified R42 as being at risk for pressure ulcers, but currently did not have a pressure ulcer. Review of the initial admission data collection tool dated 6/2/14, identified R42 as having a reddened buttock. A positioning data collection tool indicated the resident had redness of the coccyx area on 6/7/14 and 6/10/14 after 2 hours of pressure when lying in bed. The positioning assessment and evaluation form dated 6/10/14, indicated the resident had a reddened coccyx and skin turgor was poor. It further included R42 should be repositioned every 2 (two) hours and to relieve pressure from the coccyx. Review of the short term care plan dated 6/2/14, indicated R42 had alteration in skin integrity related to immobility. The care plan did not address nor include interventions related to the reddened area on the coccyx that was identified upon admission. Review of the nursing assistants care plan for care delivery did not include interventions nor a repositioning program as described in the positioning assessment evaluation. Interview with the director of nursing (DON) on	F 314		

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F 314	Continued From page 18 6/8/14, at 1:00 p.m. confirmed resident care is delivered per the care plan. The DON further included the short term plan of care for R42 did not identify the residents pressure ulcer nor were interventions implemented to maintain skin integrity/promote healing.	F 314		

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GOOD SAMARITAN SOCIETY - WATERVILLE	205 FIRST STREET NORTH WATERVILLE, MN 56096

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMC-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Good Samaritan Society Waterville was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok TB 8-15-14 RECEIVED AUG 15 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 7-10-14 Dc: 8-19-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8-14-14

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245294	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	07/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Waterville is a 1-story building with no basement. The building was constructed in 1971 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors, that are monitored for automatic fire department notification. The facility has a capacity of 33 beds and had a census of 28 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

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

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K 062	Continued From page 2 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 9-4.2.1 and 10-2.2. This deficient practice could affect all 33 residents Findings include: On facility tour between 8:30 AM and 10:30 AM on 07/08/2014, a review of the Olympic annual fire sprinkler inspection records dated 11/18/13 indicated the following: 1. There was no 5 year internal inspection of the check valves 2. There was no 5 year internal inspection of the system pipes There was no documentation stating the above has been corrected. These deficient practices were confirmed by the Facility Maintenance Director (WB) at the time of discovery.	K 062	K-062 Olympic Fire Alarm Protection performed the 5-year testing on 8/19 date. TELS Preventative Maintenance System will be implemented on 8/21 to ensure complete documentation	8-21-14
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in	K 144		

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K 144	Continued From page 3 accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 33 residents. Findings include: On facility tour between 8:30 AM and 10:30 AM on 07/08/2014, documentation review of the weekly inspection logs (07/08/2013 to 07/08/2014) for the diesel emergency generator revealed that the weekly operational inspection were missed for the weeks of 12/9, 12/16,12/23 and 12/30/13. This deficient practice was confirmed by the Facility Maintenance Director (WB) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144	K144 Weekly operational inspections of emergency generator will be completed weekly x4 monthly x3. TELS Preventative Maintenance System will be implemented on 8/21 to ensure complete documentation	8-21-14

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 2130

July 28, 2014

Ms. Katie Davis, Administrator
Good Samaritan Society - Waterville
205 First Street North
Waterville, Minnesota 56096

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5294023

Dear Ms. Davis:

The above facility was surveyed on July 7, 2014 through July 10, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

General Information: (651) 201-5000 * TDD/TTY: (651) 201-5797 * Minnesota Relay Service: (800) 627-3529 *
www.health.state.mn.us
For directions to any of the MDH locations, call (651) 201-5000 * An Equal Opportunity Employer

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Kathyrn Serie, Unit Supervisor
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529

Telephone: (507) 537-7158
Fax: (507) 344-2723

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathyrn Serie at the number above.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118   Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Original - Facility
Licensing and Certification File   5294s14lic