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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QFGN

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 **05/26/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (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
	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 :
Kamala Fiske-Downing, Enforcement Specialist 05/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/02/2015 (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
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
05/14/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245549

June 19, 2015

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

Dear Mr. Swoboda:

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

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

Effective May 7, 2015 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, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 26, 2015

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

RE: Project Number S5549025

Dear Mr. Swoboda:

On April 24, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 9, 2015. 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 May 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 18, 2015 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 April 9, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 7, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 9, 2015, effective May 7, 2015 and therefore remedies outlined in our letter to you dated April 24, 2015, 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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245549	A. Building B. Wing	5/26/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE 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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0154** Reg. # **483.10(b)(3), 483.10(d)(2)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/30/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/04/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/07/2015**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	05/26/2015	03048	05/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
4/9/2015	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245549	A. Building B. Wing 01 - MAIN BUILDING 01	5/18/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE 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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 04/10/2015	ID Prefix Reg. # NFPA 101 LSC K0022	Correction Completed 04/17/2015	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 04/10/2015
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	05/26/2015	35482	05/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
4/7/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QFGN

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 **04/09/2015** (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:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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 :
Lois Boerboom, HFE NE II 05/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/12/2015 (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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 24, 2015

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

RE: Project Number S5549025

Dear Mr. Swoboda:

On April 9, 2015, 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. In addition, at the time of the April 9, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number .

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. In addition, at the time of the April 9, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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

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

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

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

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
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
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 May 19, 2015, 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 May 19, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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 July 9, 2015 (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 October 9, 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
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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	04/09/2015

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to fully inform the resident of changes in their treatment for 2 of 3 residents (R9 & R40) reviewed for participation in their plan of care. Findings include: R9 was readmitted on 1/27/14, following hospitalization with diagnoses listed on the	F 154	Current meds, treatments and lab results have been reviewed with R9 and R40. All new orders, labs results and changes to each resident's plan of care are being addressed with the resident and / or their responsible party as they occur unless the resident or their responsible party indicate they prefer otherwise. Professional	4/30/15

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

Electronically Signed | 05/04/2015

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 _____	04/09/2015

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

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F 154	Continued From page 1 electronic record diagnosis list which included: unspecified hypertension, anemia, congestive heart failure, (CHF), peripheral neuropathy (nerve impairment to legs), gout, history (hx) venous thrombosis (blood clot) and embolism (blockage in a blood vessel), osteoporosis, urinary tract infection (UTI), generalized pain, spinal stenosis, esophageal reflux, and insomnia. Review of the most recent Minimum Data Set (MDS) dated 1/15/15, indicated R9 had a Brief Interview For Mental Status (BIMS) score of 14/15 which indicated cognition was intact. Review of the nursing progress notes dated 3/30/15, at 15:00 [3:00 p.m.] indicated R9 had an order for Senna Tablet 1 by mouth (PO) two times a day related to unspecified constipation. This was noted as "requested". There was an additional progress note dated 3/30/15, at 09:04 which included a note that R9 had "loose bowels and does not want it unless she can not go". The next notation at 10:35 was related to a faxed communication with the physician, and indicated R9 was describing her discomfort as "gas pains" and had requested Kaopectate. This notation further indicated the resident can not have Kaopectate due to interaction with Warfarin and requested something different for gas pains. The physician order received gave the direction to decrease Senna to as needed (PRN). An additional order for Miralax 17 gm PO daily (QD) was also received and dated as 4/1/15. During an interview on 4/7/15, at 10:00 a.m. R9 indicated the change in orders for Senna and Miralax was a recent occurrence in which she was not informed of the medication changes nor the response from the physician regarding her plan of care. R9 further stated that she frequently	F 154	nurses were educated on April 14, 2015 as to the need to report all changes in medications and lab results to the resident and document that this was accomplished. All new orders and labs will be audited for compliance by the Director of Nursing or her designee for 2 weeks, then 25 orders or labs per week for 2 weeks, and then 15 orders per week for the following 2 months. All audit results will be reported monthly to the Quality Assurance / Performance Improvement Committee and determination of further action if needed will be determined by the interdisciplinary committee. Completion Date: April 30, 2015	

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did not know of a change in her medication orders and/or treatments until the nurse entered the room to administer the medication or perform the treatment and she had to ask about the change.

During an interview on 4/07/15, at 2:30 p.m. registered nurse (RN)-B verified R9's orders changed; adding Miralax 17 gm PO QD and Senna 1 tablet PO BID changed to PRN on 3/30/15. RN-B confirmed the progress notes contained a notation, which she had made that the physician order had been received, but there was no documentation, nor did she recall whether R9 had been informed of the change. RN-B further stated the facility practice was to note the physician order, document receipt of the order in the progress notes, and then inform the resident or family of the change.

On 4/08/15, at 8:33 a.m. during a subsequent interview R9 stated, when a medication or treatment was changed she was not aware of the change until staff came into the room and she had to ask what something was. R9 further verified that if she requested the physician be updated on an issue, the nurse let the physician know but she would not be informed of the physician response nor whether the physician had even been notified. This information was only communicated if she asked.

R40 was admitted on 7/12/12, with diagnoses listed on the electronic record diagnosis list which included: CHF, Shortness of breath, disorder of stomach, edema, urinary frequency, generalized pain, hypothyroidism, depressive disorder, and atrial fibrillation. Review of the most recent MDS dated 2/19/15, indicated R40 had a BIMS score of 15/15 which indicated cognition was intact

During an interview on 4/07/15, at 2:01 p.m. R40

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stated, when a medication or treatment is changed the staff just bring it in or provide the treatment. R40 further stated if she doesn't ask about a change in her medication or treatment than no one says anything. R40 stated she had brought up the issue of having to go to the toilet so frequently and not being able to attend activities, etc. for fear of having to use the toilet. She further stated the nurses had said they would contact the MD, but she hadn't heard anything following that communication. R40 stated she receives a blood thinner medication, "Coumadin" and blood is drawn occasionally but she doesn't know what the results are or what dosage of medication she is to receive as a result of the test.

Review of R40's nursing progress notes indicated an entry dated 3/6/15, at 15:59 (approx. 4:00 p.m.), "Resident up at desk and voices concerns about how much time she spends in the bathroom after breakfast until after lunch. Fax sent to [physician] informing him of concerns". A faxed response was received and noted on 3/9/15 which indicated, "Based on history (Hx) I agree the findings are consistent with the use of diuretics. We will continue to watch".

On 4/07/15, at 1:15 p.m. the director of nursing (DON) was interviewed and stated changes are recorded in the electronic medication administration record (EMAR) and if the resident is alert and oriented they are made aware of change, if they are not able to make their own choices then the family is notified. The DON further stated the MD makes rounds and speaks with the resident about the treatments or medications being considered. Since the resident is usually involved in the initial conversation no additional notification of the new order is made.

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F 154	Continued From page 4 During an interview on 4/07/15, at 1:50 p.m. nursing assistant (NA)-D indicated R9 and R40 were alert and oriented and able to determine if there is a change in something regarding the plan of care. During interview on 4/08/15, at 8:07 a.m. the licensed social worker (LSW) stated R9 and R40 attend care conferences and are able to express their wishes in addition to making their preferences known. The DON was again interviewed on 4/08/15, at 9:29 a.m. and confirmed notification of a resident or family would be completed if there was a "major" change. The DON further stated she wouldn't expect the resident to be updated if it was not a major change as staff were busy and wouldn't always have time. The DON did confirm residents have the right to be informed of changes related to their care and/or treatments and verified this practice was not being followed according to facility policy. The Good Samaritan Society Procedure, "Notification of Condition Change and Observation" Listed Function-Nursing Services; Number II.N.7a; Issued September 2012. Procedure: It is recommended when communication is received from staff members that there is a change in condition in a resident, complete the following steps: #4. Notify the resident's responsible party and document in the Progress Notes (PN); Documentation: PN-Communication with Resident/Family. The Good Samaritan Society Policy "Care Plan" Function - Nursing Services Number II.C.3 Issued September 2012. Purpose: to develop a comprehensive care plan using an interdisciplinary team approach. Policy: The resident/family or legal representative will have the opportunity to participate in the planning of	F 154		

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F 154	Continued From page 5 his/her care, to the extent practicable. The Good Samaritan Society Procedure "Physician's Orders" Function Nursing Services Number II.P.9a; Issues September 2012/ Revised 4/13; 10/13. Documentation Flow: If orders are received for appointment, pharmacy orders, referrals, labs or other diagnostic tests, follow your center's procedure for noting, notifying appropriate parties including the resident's family/responsible party and scheduling of these orders.	F 154		
F 248 SS=D	. 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide an individualized activity program for 1 of 3 residents (R3) reviewed for activities. Findings include: R3 was admitted on 7/31/1998 with diagnoses obtained from the electronic medical record under the heading of "Diagnosis List": occlusion & stenosis carotid artery, macular degeneration, edema, generalized pain and history (hx) of trans-ischemic attack (TIA).	F 248	The Activity goal and plans for R3 have been reviewed and her care plan has been adjusted to reflect changes needed to meet her needs. The activity participation reports for all other resident have been reviewed and updated as needed. The Activity Department staff was educated on April 15, 2015 as to the need for diversional programing and what constitutes a 1:1 visit and how to do adequate charting for each resident. The Activity Director or her designee will audit activity reports and 1:1 visit reports for	4/30/15

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F 248	Continued From page 6 The most recent Minimal Data Set (MDS) assessment dated 3/4/15, contained a Brief Interview for Mental Status (BIMS) score of 99, indicating staff were unable to complete the assessment due to R3's severely impaired cognition. R3's activities of daily living (ADLs) skills related to bed mobility, transferring, dressing, grooming and personal hygiene required extensive assistance from staff. R3 was noted to have difficulty communicating her preferences and demonstrated dependence on staff for anticipation of needs. The Care Plan Focus with a revision date of 3/9/15, indicated R3 had impaired cognitive function/dementia or impaired thought related to short and long term memory loss and distractibility. The Care Plan Focus with a revision date of 3/27/14, indicated R3 had a communication problem related to hearing deficit, Parkinson's disease evidenced by quiet and slurred verbal communication, difficulty with message integration and searching for words. The Care Plan Focus with a revision date of 3/24/14, indicated R3 is dependent on staff for activities, cognitive stimulation and social interaction related to cognitive deficits and physical limitations. It was observed on 4/06/15, at 7:07 p.m. that R3 was seated in a Rock n Go chair in the lobby area in front of the TV located adjacent to the 300 wing. R3 showed no interest in the TV program. R3 was observed picking at the blanket and chair cushion in the lobby area. No residents nor staff were noted to be located in the immediate area. Staff were observed walking past, but didn't attempt to communicate nor interact with R3.	F 248	those residents needing them weekly for 2 months and then monthly thereafter. Results of these audits will be presented at the monthly Quality Assurance / Performance Improvement Committee and any further action, if necessary, will be determined by the interdisciplinary team. Completion Date: April 30, 2015	

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F 248	Continued From page 7 During the morning of 4/07/15, at 10:30 a.m. R3 was transported from the dining room and placed in the lounge area across from the 100 wing after breakfast. R3 was positioned in her Rock n Go chair near a table which contained newspapers and magazine. R3 was noted to lean forward in her chair, with her eyes closed and appeared to be sleeping. The scheduled 10:30 a.m. activity was identified as Making Lemon Pies which R3 was not a participant. R3 remained in the lounge area until nursing assistant (NA)-D transported her into her room to provide toileting needs and then into bed for a morning nap. R3 remained in bed until it was time for the noon meal. During the afternoon of 4/7/15, at 1:59 p.m. R3 was observed seated in her Rock n Go chair in her darkened room, in front of the TV. When interviewed on 4/7/15, at 2:00 p.m. NA-D indicated R3 had eaten her noon meal in the main dining room, was transported back to her room for assistance with toileting and subsequently R3 was watching TV in her room. R3 remained in her room, in front of the TV until 2:47 p.m. when R3 moved herself in the Rock n Go chair into the darkened bathroom. The resident's door was noted to be partially closed. At 3:00 p.m. NA-D and NA-G entered R3's room and stated they were going to assist R3 to the toilet. After toileting was completed, R3 was again placed in front of her TV. The scheduled afternoon activity according to the activity calendar was 2:00 p.m. afternoon coffee. R3 remained in her room, alone, during this time. At 3:15 p.m. R3 was transported from her room and placed in the lounge area across from the 100 wing. At 3:33 p.m. R3 was observed seated in her Rock n Go chair with her eyes closed, facing	F 248		

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the nursing station. No staff were observed in attendance nor were any scheduled activities noted in the area where R3 was seated. According to the activity calendar, the 3:00 p.m. activity was "Heaven is for Real", a book reading. It was noted the activity scheduled for 3:30 p.m. was the Cornerstone Church service, provided via the television located in the activity area. During this time the activity director and multiple nursing staff were observed walking past R3, but no one attempted to communicate with nor invite R3 to attend any scheduled activities.

After the surveyor questioned the activity director (AD), the AD transported R3 at 3:50 p.m. into the activity room so that she could participate in the church service activity, which had begun 20 minutes earlier. R3 did not appear to be interested in the program and at 4:04 p.m., activity staff transported her from the area. According to the activity staff, R3 was restless and when asked whether she wanted to watch the 'other' TV, R3 replied "yea". R3 was observed seated in the lounge area adjacent to the 300 wing. R3 was fidgeting with the blanket located on her lap and the right arm tray. R3 did not show interest in watching the TV program. No staff were in the area to provide interaction with R3.

The following morning, on 4/8/15, at 8:00 a.m. R3 was observed seated in her Rock n Go chair as she was transported to the dining room for breakfast. After completion of breakfast, R3 was again transported back to the lounge area adjacent to the nursing station where she remained in the Rock n Go. R3 appeared to be sleeping. At 10:00 a.m. R3 was transported to the resident council meeting held in the activity

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room and then returned to the lounge area in front of the TV. R3 was observed to occasionally look at the television, but didn't appear to be interested in the program. R3 watched persons walking past but didn't make any attempt to communicate with them. At 11:30 a.m. R3, located in the lounge across from the nurses' station, was observed turning pages in a magazine. After the noon meal, at 12:20 p.m., R3 was seated in her Rock n Go chair, in the lounge area with her eyes closed and tongue protruding from her mouth. R3 was observed in her room at 12:30 p.m. seated in the Rock n Go chair with the partial tray table raised and her face resting against the edge of the tray. NA-F entered the room, repositioned R3 and left her in front of the TV when exiting the room.

During an interview on 4/7/15, at 1:48 p.m. NA-D stated R3 is transported to activities at times; likes to sit at the table and look at magazines and likes to rummage in her belongings when in her room. NA-D further stated she was uncertain whether R3 attended group activities.

When interviewed on 4/7/15, at 2:48 p.m. the AD stated that spirituality is very important to R3 so she is invited to religious activities and her sister-in-law comes weekly and assists her to play Bingo. The AD further stated that R3's abilities had declined in the past year and she will remove herself from an activity. The AD further clarified, "when staff have time they will perform a 1:1 activity with R3, but R3 is not on the 1:1 schedule for routine visits". The AD indicated that staff will transport R3 to group activities, she becomes restless after a short time and then will wheel herself out from the activity. She further stated there was not a specific activity plan for R3

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and R3 has difficulty maintaining focus in a group activity.

During interview on 4/7/15, at 3:48 p.m. licensed practical nurse (LPN)-B indicated she positioned R3 at the table in the lounge area as, at times, R3 will sit and look at papers at the table. LPN-B further confirmed that, at this time, R3 did not appear interested in the papers nor magazines. LPN-B indicated she had not offered R3 any activity prior to transporting R3 to the lounge area. LPN-B stated that R3 likes to rummage in drawers when in her room and at times likes to look at papers and magazines. She further stated that on Wednesday and Sunday nights, R3 likes to attend Bible study, enjoys singing and chapel services.

When interviewed on 4/8/15, at 8:15 a.m. the licensed social worker (LSW) stated she was not aware of any family requests that be included/not included in activity programs. The LSW further stated that R3 "roams" down the halls in her chair and when involved in an activity, she doesn't stay 'put' for long. The LSW further indicated she was not aware of any individualized activity plan for this resident.

During an interview on 4/8/15, at 12:01 p.m. NA-G indicated staff attempt to take R3 to group activities and encourage her to participate, but she becomes restless after a short time. NA-G indicated R3 will attempt to verbalize with persons at times when they are located next to her or passing next to where she is seated.

During an interview with NA-F on 4/08/15, at 12:42 p.m. it was confirmed that R3 will occasionally attend news and activities, and likes

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to look at magazines. NA-F stated that following cares R3 is usually either in her room or in one of the lounge areas.

During interview on 4/8/15, at 12:04 p.m. LPN-A confirmed R3 will listen when taken to news, exercise and/or music programs. LPN-A indicated she was aware the activity staff provided 1:1 activities but was uncertain whether R3 was included. LPN-A stated she felt R3 would benefit from a 1:1 type program.

When interviewed on 4/8/15, at 12:13 p.m. the AD indicated that resident attendance and participation in activity programs is documented on a daily basis, ideally after each activity. The AD indicated that determination whether a resident would benefit from 1:1 staff/resident interactions is based on whether a person is able to engage themselves in independent or in group activities. The AD further clarified that a resident who was not aware of group activities or able to participate would be a candidate for 1:1 activities. The activity director concluded that R3 would benefit from 1:1 type activities.

During an interview on 4/8/15, at 2:01 p.m. the director of nursing (DON) stated she believed R3 would benefit from 1:1 activities and R3 is responsive to communication and offers vocalization. The DON further stated that when sitting with R3 "even if she is unable to understand the conversation, R3 responds positively to the interaction". The DON indicated that R3 tends to wander and doesn't engage in group activities and does better with 1:1 focused activities.

Review of activity documentation for March 2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 12 indicated R3 attended a total of nine group activities and documentation for April 2015 revealed R3 had not attended any activities until the church service on 4/7/15. The activity assessment/note dated 3/5/15, at 09:31 a.m. had the following documentation: Have the care plan goals been met: Resident has generally been able to meet her care plan (CP) goal of attending a minimum of 3 spiritual activities/month; as spiritual activities have been identified as being very important to resident, this continues to be an appropriate goal at this time. Response to plans/interventions: continues to become anxious during most group activities and usually attempts to transport herself out of activity 5-10 minutes after being brought in by staff, d/t (due to) her poor eyesight and inability to maneuver wheelchair, resident bumps others and becomes stuck. Staff is encouraged to place near an accessible exit so as not to disrupt others. Spends most of the day wheeling herself through the halls and falls asleep easily. Wanderguard remains on rock n go chair, but this has not been an issue throughout this review period. Due to significant cognition deficits, resident does not actively engage in most group activities. She will attempt to initiate conversation with other residents but she is unable to accurately track conversation and/or offer more detailed explanations. She also has a tendency to rummage and/or play around with potted plants/flowers. Resident has cut plants in lounge area. Staff attempt to anticipate and remove such objects from easily accessible areas away from resident. Staff continue to offer assistance with reading mail for resident prn. No changes to resident's interventions are necessary at this time.	F 248		

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	245549	A. BUILDING _____ B. WING _____	04/09/2015

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GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

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F 248	Continued From page 13 Another electronic entry from the MDS dated 3/4/15 at 10:22 a.m. indicated the following: Resident's cognition continues to decline and she is generally unable to either accept or decline invitations to activities when offered to her. Staff will anticipate activities of interest. Has difficulty expressing herself, but has moments when she expresses concern and urgency for others around her. She is unable to track conversation with others most of the time. Resident will attempt to initiate conversation with other residents when wheeling through the hallways and sitting in the lounge. Resident's sister-in-law visits at least weekly and will assist her with playing bingo.	F 248		
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	F 279		4/30/15

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F 279	Continued From page 14 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 comprehensive care plan that identified risks, goals and interventions for fall risk for 1 of 3 residents (R46) reviewed who had a history of falls. Findings include: R46 had diagnoses that included: depression, macular degeneration, hypertension, hearing loss, pain and insomnia listed on her medical diagnoses list in the electronic health record (EHR). During interview with registered nurse (RN)-A on 4/6/15, 3:08 p.m. it was stated by RN-A that R46 had a fall in the past 30 days, had a history of falls and R46 was blind and deaf. The medical record identified R46 had a long history of falls dating back to the time of her admission on 2/12/13. During review of R46's EHR the following accidents were noted: (1.) On 3/29/2015, at 9:50 p.m. a progress note identified R46 was found sitting in doorway of her room leaning on the doorframe. R46 was yelling out,"Help I've fallen and I can't get up". R46's range of motion (ROM) was assessed with no noted deficiencies. There were no observed or assessed injuries. (2.) On 3/23/2015, at 1:55 p.m. a progress note identified R46 was found seated on the floor of her room in next to her recliner. There was no injury noted by the nurses assessment nor indicated by R46. R46 was assisted up and into	F 279	R46 has had her care plan updated to reflect her risk factors for falls and a goal established. Current approaches for fall prevention which were already on the care plan were moved to the risk goal so as to be easily identified. All residents who have had falls in the past 6 months and those at high risk for falls have been assessed and their care plans updated to indicate what their risk factors are. Professional nurses were educated on April 14, 2015 on the need to investigate and identify factors contributing to each fall and reporting these. All nursing staff were educated on the need for identifying risks on April 23, 2015 and April 30, 2015. Care plans for those residents with subsequent falls or those to be determined to be at high risk for falling will be reviewed at the time of each fall to determine if current risks are identified and the care plan reflect all current practices. The Director of Nursing or her designee will audit all care plans of those residents with falls and those at high risk for falls for the next 2 months to insure compliance. Then 1-2 residents per month will be audited for the next 2 months. All audit results will be reported at the monthly Quality Assurance / Performance Improvement Committee and determination of further action, if necessary, will be determined by the interdisciplinary Committee. Completion	

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GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

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F 279	Continued From page 15	F 279	Date: April 30, 2015	

her recliner.
(3) On 2/24/2015 at, 7:50 a.m. a progress note identified R46 was heard by a NA (nursing assistant) calling out "Yoo-hoo" from her room. When the NA entered R46's room the NA found R46 sitting on the floor next to recliner. R46 told staff that she was trying to pick something up off of the floor. There were books lying next to R46 on the floor at the time. R46 was assessed and did not have any obvious injury or complaints of pain.

The medical record included a Post Fall assessment dated 4/2/15, which identified R46 to be at risk for falling related to a history of falls, medication regimen, diagnoses, vision impairment, incontinence and use of assistive devices. The assessment identified interventions that were to be implemented after the fall (3/29/15) to include-place walker close to the bed so R46 would use it versus trying to use the bedside table as a walking support. The assessment identified that R46 would use the table as a walker instead of her four wheeled walker; most likely related to her visual impairment and inability to differentiate between the walker and table. There was no care plan developed related to the risk factors, goals or interventions related to falls for R46.

R46 was observed throughout the survey from 4/6/15 to 4/9/15 and noted to spend most of her days in her room with the room door partially closed.

During interview with on 4/07/15, at 2:01 p.m. RN-A verified R46's care plan did not have a fall specific risk area. RN-A stated R46 would spend most of her days in her room sleeping and was

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F 279	Continued From page 16 not very active in the facility activities. RN-A stated some of the interventions related to fall risk were part of her mobility plan of care, such as placing a stationary bedside table in her room versus table with wheels. RN-A verified there was not a fall risk plan of care developed which included identified goals and interventions. The facility "Care Plan" policy, dated September 2012, identified "Each resident would have a comprehensive plan of care that would include measurable goals and timetables directed towards achieving and maintaining the residents optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of physician orders, any problems, needs and concerns identified will be assessed".	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the written plan of care for 1 of 1 resident (R46) reviewed who was identified with a stage one (1) pressure ulcer. Findings include:	F 282	A new memory foam pillow has been ordered for R46. All care plans were reviewed for other residents with skin issues to determine if interventions were established and being followed. All nursing staff were educated on April 14, 2015, April 23, 2015 and April 30, 2015 on	4/30/15

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F 282	Continued From page 17 R46 had diagnoses that included: depression, macular degeneration, hypertension, hearing loss, pain and insomnia as listed on her medical diagnoses list in her electronic health record (EHR). During interview on 4/6/15, at 3:07 p.m. registered nurse (RN)-A stated R46 had a Stage 1 pressure ulcer (PU) located on the top part of her right ear. RN-A further clarified that R46 would often lie on her right side and spend much of the day laying in bed. Stage 1 pressure ulcer is a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues. R46's current care plan dated 3/14/15, identified R46 with a potential for skin breakdown related to decreased mobility, incontinence and chronic inflammation of the right ear ear she as prefers to only lay on the right side. The care plan goal was to have R46 maintain intact skin and have minimal redness. The care plan goal was to have R46 maintain intact skin and have minimal redness. The care plan interventions included: (1) Encourage to avoid lying on right side; (2) guide her onto left side or back when helping into bed or if seen lying on right ear; (3) prop feet & ankles off of mattress with pillows as resident will allow; and (4) attempt to take off shoes at bed time. Other interventions included: (4) foam cushion in her wheelchair and (5) monitor right ear, ankle, & both feet for worsening redness, swelling, tenderness and notify nurse immediately of any new concerns. On 4/7/15, at 12:57 p.m. R46 was observed lying in her bed on her right side with the right side of	F 282	the need to be aware of what care plan approaches and interventions have been established for this resident as well as all other residents and how to locate these approaches on the EHR. Observations and staff interviews regarding current approaches, interventions and the implementation of these will be done by the Director of Nursing or her designee on 2-3 residents per week for the first month and then 2-3 residents per month for the next 2 months. All audit results will be reported at the monthly Quality Assurance / Performance Improvement Committee meeting and any further action, if necessary, will be determined by the interdisciplinary committee. Completion Date: April 30, 2015	

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F 282	Continued From page 18 her face laying on the pillow. On 4/7/15, at 1:35 p.m. R46 remained in bed laying on her right side. On 4/7/15 at 2:24 p.m. R46 remained in bed lying on her right side with her right ear pressed upon pillow and at 2:58 p.m. remained resting in bed, lying on her right side with the right ear against pillow. During further observation on 4/7/15, at 3:47 p.m. R46 remained in bed lying on her right side with her ear against the pillow. At 3:48 p.m. nursing assistant (NA)-C entered R46's room to deliver R46 a fresh pitcher of water. NA-C replaced R46's old water pitcher with a fresh water pitcher and left a snack. NA-C then moved the bedside table and exited the room without encouraging R46 to change positions. On 4/7/15, at 3:49 p.m. NA-C was interviewed and asked whether there were any special cares/interventions for R46. NA-C stated staff were to keep her calm and if she was resting not to disturb her. NA-C was not aware of any skin interventions. R46 remained lying on her right side until 4:05 p.m. (3 hours and 8 minutes) before staff repositioned her by assisting R46 out of bed. When interviewed on 4/7/15, at 3:28 p.m. RN-A stated there was not any schedule developed to have staff monitor R46 to determine whether she was laying on her right side. RN-A stated that staff repositioned R46 onto the left side and R46 would reposition herself back to right side. Staff failed to encourage R46 to move off of her right side when lying in bed (over 3 hours) as written in the plan of care.	F 282		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		4/30/15

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F 314 SS=D	Continued From page 19 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, document review and interview the facility failed to promote the healing of a pressure ulcer located on the right ear for 1 of 1 resident (R46) reviewed who had a Stage one (1) pressure ulcer. Findings include: R46 had diagnoses that included: depression, hearing loss, pain and insomnia as listed on her medical diagnoses list in the electronic health record (EHR). During interview on 4/6/15, at 3:07 p.m. registered nurse (RN)-A stated R46 had a Stage 1 pressure ulcer (PU) located on the top part of her right ear. RN-A further clarified that R46 would often lie on her right side and spend much of the day lying in bed. Stage 1 PU defined as: An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: -Skin temperature (warmth or coolness); -Tissue consistency (firm or boggy); -Sensation (pain, itching); and/or -A defined area	F 314	A new memory foam pillow has been ordered for R46. The care plans and interventions for this resident and all other residents with pressure areas or significant skin issues were reviewed and updated if necessary. All Nursing staff were educated on April 14, 2015, April 23, 2015 and April 30, 2015 on the need to be aware of care plan interventions for this resident pertaining to her pressure area as well as other residents with specific approaches. Observation and staff interviews regarding current approaches, interventions and the implementation of these will be done by the Director of Nursing or her designee on 2-3 resident per week for the first month and then 2-3 residents per month for the next 2 months. All audit results will be reported monthly to the Quality Assurance / Performance Improvement Committee and any further action, if necessary, will be determined by the interdisciplinary team. Completion Date: April 30, 2015	

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F 314	Continued From page 20	F 314		

of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

On 4/7/15, at 12:57 p.m. R46 was observed lying in her bed on her right side with the right side of her face laying on the pillow. On 4/7/15, at 1:35 p.m. R46 remained in bed laying on her right side. On 4/7/15 at 2:24 p.m. R46 remained in bed lying on her right side with her right ear pressed upon pillow and at 2:58 p.m. remained resting in bed, lying on her right side with the right ear against pillow.

During further observation on 4/7/15, at 3:47 p.m. R46 remained in bed lying on her right side with her ear against the pillow. At 3:48 p.m. nursing assistant (NA)-C entered R46's room to deliver R46 a fresh pitcher of water. NA-C replaced R46's old water pitcher with a fresh water pitcher and left a snack. NA-C then moved the bedside table and exited the room without encouraging R46 to change positions.

On 4/7/15, at 3:49 p.m. NA-C was interviewed and asked whether there were any special cares/interventions for R46. NA-C stated staff were to keep her calm and if she was resting not to disturb her. NA-C was not aware of any skin interventions. R46 remained lying on her right side until 4:05 p.m. (3 hours and 8 minutes) before staff repositioned her by assisting out of bed.

When interviewed on 4/7/15, at 3:28 p.m. RN-A stated there was not any schedule developed to have staff monitor R46 to determine whether she was laying on her right side. RN-A stated that staff repositioned R46 onto the left side and R46

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F 314	Continued From page 21	F 314		

would reposition herself back to right side. When asked what interventions were in place to promote healing and prevent further skin breakdown, RN-A stated staff were to encourage R46 to lay on her left side. RN-A further stated there had been no other interventions attempted to reduce pressure to the right ear since R46 preferred to rest in bed, lying on the right side.

A Braden Scale assessment dated 4/2/15, identified R46 with a score of 18 indicating her at mild risk for development of pressure ulcers. R46's risk factors were identified as poor nutrition, and friction/tear problem. The Braden scale identified interventions for residents with mild risk should include: Frequent turning (e.g., every 2 hours), maximal remobilization pressure-reduction support surfaces (if bed- or chair-bound protect heels), manage moisture, manage nutrition, and manage friction and shear. *If other major risk factors present (advanced age, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability), advance to next level of risk.

R46's current care plan dated 3/14/15, identified R46 with a potential for skin breakdown related to decreased mobility, incontinence and chronic inflammation of the right ear ear she as prefers to only lay on right side. The care plan goal was to have R46 maintain intact skin and have minimal redness. The care plan interventions included: (1) Encourage to avoid lying on right side; (2) guide her onto left side or back when helping into bed or if seen lying on right ear; (3) prop feet & ankles off of mattress with pillows as resident will allow; and (4) attempt to take off shoes at bed time. Other interventions included: (4) foam cushion in her wheelchair and (5) monitor right

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F 314	Continued From page 22 ear, ankle, & both feet for worsening redness, swelling, tenderness and notify nurse immediately of any new concerns R46's progress note on 4/2/15, timed 5:26 p.m. identified skin intact but continues to have difficulty with reopening of area on right ear; currently not open, but remains chronically red. Staff continue to encourage her to remain off right side as ankle is also intermittently red, but resident usually returns to right side side independently. The facility was unable to produce any further assessments nor interventions attempted and/or implemented to reduce the risk factors related to the recurring stage 1 ulcer. The facility policy for "Pressure Ulcers", dated September 2012, identified residents would receive appropriate assessments and services to promote and maintain skin integrity. If the resident's clinical condition makes compromise of skin integrity clinically unavoidable, this information will be documented in the medical record. The policy further identified any resident with an existing pressure ulcer would receive the necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		5/4/15

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F 315	Continued From page 23 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary cares and services to manage incontinence for 2 of 3 residents (R20 & R63) reviewed who experienced urinary incontinence. Findings include: R20 had current diagnoses which included: dementia, hypertension, anxiety, paralysis agitans, depression and history of falls identified on his medical diagnoses list in the electronic health record (EHR) During observation on 4/6/15, at 3:25 p.m. a strong urine odor was noted in the area around R20 and in his room. R20 was seated in his wheelchair in his room at the time of the observation. During a subsequent observation on 4/6/15, at 5:05 p.m. a strong urine odor was noted when R20 was seated in the dining room. R20's quarterly assessment dated 2/12/15, identified R20 as frequently incontinent of urine and required extensive assist of one staff with toileting needs. It further identified that R20 required extensive assistance of one staff with bed mobility and transfers. R20's care plan dated 2/10/15, identified bladder incontinence related to Parkinson's disease and	F 315	R20 & R63 have had Bladder Assessments completed and their care plans updated to reflect needed interventions to promote management of incontinence and promote continence as able. All other residents have had their medical record reviewed for current Bladder Assessments and any that require updating have been completed. Audits will be conducted by the Director of Nursing or her designee on current bladder data collection and the timely completion of consequent assessments for 4 residents with incontinence weekly for 2 months and then 4 residents per month for the next 2 months to insure compliance. All audit results will be reported at the monthly Quality Assurance / Quality Improvement Committee for review and any further action, if necessary, will be determined by the interdisciplinary team. Completion Date: May 4, 2015	

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 _____	04/09/2015

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
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dementia evidenced by 4-6 episodes of incontinence daily. The facility developed intervention for the incontinence that included:
1. Encourage to use the urinal when in bed and assist to place & empty as needed.
2. Utilize white hour glass pad with snap panties

A progress note dated 2/15/15, identified R20 called staff when incontinent and staff completed perineum cares and changed incontinent product. The care plan identified that R20 would take himself to bathroom at times by transferring self from wheelchair while utilizing the grab bar in the bathroom. The care plan further identified R20 transferred self in and out of bed.

During observation on 4/7/15, at 1:30 p.m. R20 was observed lying in bed while family member (FM)-B was visiting. R20 was again noted to have a strong urine odor present while lying in bed. FM-B was interviewed and stated R20 was frequently incontinent of urine but would notify staff when incontinent and they would help change his wet clothing and incontinent brief.

During interview on 4/7/15, at 1:47 p.m. nursing assistant (NA)-A stated R20 told staff when he was incontinent. NA-A stated, "He urinates heavily and is almost always wet". NA-A stated R20 was not on a toilet schedule and was checked only when he requested assistance. NA-A stated staff document incontinent episodes, which is multiple times daily.

When questioned on 4/7/15, at 1:56 p.m. p.m. whether a urinary assessment had been conducted, registered nurse (RN)-A stated she was unable to locate the assessment in R20's EHR nor in the paper medical record. When

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interviewed on 4/7/15, at 2:05 p.m. RN-B verified the record lacked any bladder assessment.

When interviewed on 4/7/15, at 2:42 p.m. NA-B indicated she had just left R20's room and helped FM-B with the provision of incontinent care for R20. NA-B indicated FM-B had already been changing the incontinent brief when she entered the room. NA-B stated R20's incontinent brief was saturated with urine and verified R20 was frequently incontinent.

During observation of resident cares on 4/8/15, at 6:45 a.m. R20 was observed seated in his wheelchair in his room and again a strong urine odor was noted. During interview with R20 at that time R20 stated he had been up since about 5:30 a.m.

During observation of morning cares on 4/9/15, at 9:42 a.m. R20 was observed lying in bed on top of blankets and the strong urine odor was present. When interviewed on 4/9/15, at 9:45 a.m. RN-A verified the presence of the urine odor, indicating it had been an ongoing problem. RN-A stated staff sometimes had difficulty getting R20 to be compliant with changing wet pads or clothing. RN-A verified that a toileting log had not been implemented so that frequency and times of incontinence could be tracked. RN-A confirmed the medical record lacked any urinary assessment.

The Care Area Assessment (CAA) conducted at the time of the annual Minimum Data Set (MDS) dated 11/13/14, identified R20 had a history of depression and had been refusing cares more frequently. The CAA identified staff would ask R20 if he needed to toilet and R20 would state he

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had just gone and then would be incontinent of urine, only minutes later. The CAA indicated staff continued to offer R20 opportunities to toilet on a scheduled basis, but the schedule was not identified. The medical record lacked a bladder assessment which identified interventions related to a toileting schedule and/or services required to address the strong urine odor and non-cooperative behaviors exhibited by R20 related to his toileting needs.
R63's medical diagnoses listed in the EHR included benign prostatic hyperplasia (BPH), bladder cancer, hypertension and degenerative arthritis. Review of R63's Assisted Living transfer form dated 12/12/14, and noted by facility staff 12/15/14 (when admitted) R63 had "some incontinence of B & B (bowel and bladder).

During review of the MDS dated 12/19/14, it indicated R63 as continent and the subsequent quarterly assessment dated 2/26/15, indicated occasional incontinence as well as intact cognition. Both assessments documented that R63 had intact cognition and was independent with activities of daily living (ADLs).

A 72 hour bowel and bladder monitoring (upon admission) indicated that on 12/15/14, voiding occurred 2 times from 1:05 pm to 12:00am; on 12/16/14, occurred 6 times in 24 hour (hr) period; on 12/17/14, occurred 12 times in 24 hr period; and on 12/18/14, occurred 7 times in 24 hr period. The monitoring form indicated that R63 was either continent, did not void and/or refused toileting.

The social services admission note dated 12/15/14, indicated C63 as having episodes of intermittent confusion and is incontinent of bowel

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and bladder. Documentation revealed C63 has been reluctant to ask for assistance with toileting and had not been able to manage incontinence satisfactorily himself.

During an interview on 4/8/15, at 11:38 a.m.RN-C indicated that a 72 hr bladder monitoring was completed upon admission and consisted of hourly monitoring (voiding) with documentation. She verified the documentation for C63 did not occur every hour during the initial 72 hr. bladder monitoring timeframe as required. RN-C verified that no further bladder monitoring had occurred since the quarterly assessment dated 2/26,15, which indicated R63 had experienced more episodes of urinary incontinence. RN-C reported that R63's family member reported to her on 12/24/14, regarding concerns of urinary leakage and so a pull up brief was initiated. The plan of care was updated to reflect potential for incontinence on that date. RN-C reported that R63 does not seem to have incontinence issues during the day and the family member will notify staff if she noted any potential urinary incontinence.

During an interview on 4/8/15, at 12:10 p.m. family member (FM)-A reported that R63 has had urinary incontinence issues for a couple of years and had strong smelling urine. FM-A reported staff was made aware of the incontinence "in passing" during frequent visits and also at care conference meetings. FM-A reported leaving a note for RN-C indicating R63 had a couple of incontinent mishaps on 3/20/15 and suggested that pull up briefs be utilized during the day as well as at night but that had not yet occurred. FM-A further reported that R63 urinates frequently and was incontinent last Thursday

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During an interview on 4/8/15, 12:45 p.m. R63 verified that he considered his bladder leakage a problem and that he has a diagnosis of bladder cancer but had declined further treatment. R63 further indicated he awakens during the night to void.

During an interview on 4/9/15, at 8:25 a.m. the director of nursing (DON) reported that R63 was basically independent with toileting. The DON indicated that bladder monitoring is to be completed within 72 hrs of admission but if resident is independent and continent of urine, a bladder assessment would not be completed. The DON further clarified she would have expected a bladder reassessment be conducted after a family member reported incontinence issues communicated on 12/24/14. This assessment would be completed prior to planned interventions. The DON further stated, "We should have tried to manage his incontinence and documented his refusals or acceptance".

Review of the Policy for Bladder Assessment dated 9/2012, the procedure indicates (1.) Documentation of bowel and bladder habits should occur hourly for at least the first 72 hours following admission. When this is completed in POC (point of care-CNA documentation), resolve the 72 hr bowel and bladder task and activate the Bladder and Bowel task on the resident chart. The Bladder Incontinence Data Collection UDA and Bladder Assessment UDA, are auto-created on admission and should be completed after the 72 hrs of bowel and bladder monitoring are complete. (2.) Using the CAA's, determine if an treatable or contributing conditions exist. (3.) A

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F 315	Continued From page 29 pharmacological evaluation should be completed. (4.) A review of the resident's diet also is suggested. The medical record failed to identify the type of bladder incontinence R63 experienced nor did it identify interventions required to provide the appropriate services to promote normal bladder function other than an incontinent brief.	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain dairy products served to residents that were within the expiration date as indicated on the gallon milk containers. This practice had the potential to affect 54 of 55 residents who reside in the facility and were served outdated milk. Findings include: During the initial kitchen tour on 4/6/15, at 1:45 p.m. with the certified dietary manager (CDM) the refrigerator located in the kitchen food service	F 371	The milk with the expired dates was immediately disposed of upon discovery. The Dietary staff were informed on the spot and all dietary staff will be educated on May 7, 2015 on the need to inspect all dates prior to serving foods. A twice weekly inspection calendar has been established. The Dietary Manager or her designee will audit all milk products for expiration dates 2 times weekly for one month and weekly for 2 months to insure compliance. All audit results will be reported at the monthly Quality Assurance	5/7/15

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F 371	Continued From page 30 area was noted to contain milk products which were past the expiration date listed on the container and were currently used by dietary staff. The refrigerator had two doors and could be accessed by staff from either the kitchen and/or the main dining room. This refrigerator was noted to contain a 1/2 (one-half) gallon of whole milk with an expiration date of 3/27/15 (10 days prior); a 1/4 (one-quarter) gallon of whole milk with an expiration date of 3/31/15 (6 days prior); a 3/4 (three-quarter) gallon of whole milk with expiration date of 3/27/15 (10 days prior); and an unopened gallon of whole milk with and expiration date of 3/31/15 (6 days prior). During interview with the CDM at the time of the observation on 4/6/15, at 1:45 p.m. the CDM stated the milk delivery person was supposed to remove outdated milk from the refrigerator and apparently hadn't done so. The CDM verified the identified milk was currently being served to residents. The CDM removed the milk from the refrigerator and stated it would not be acceptable to use the expired milk.	F 371	/ Performance Improvement Committee for review and any further action, if necessary, will be determined by the interdisciplinary team. Completion Date: May 7, 2015	

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	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/07/2015**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 7, 2015. At the time of this survey, Building 01 of Good Samaritan Society Mountain Lake was found not to be 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) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/04/2015

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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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Good Samaritan Society Mountain Lake was constructed as follows: The original building was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 2000 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The 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 54 beds and had a census of 54 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, doors were not equipped with latching hardware, preventing the doors from positively latching into their frames. This deficient practice was not in accordance with NFPA 101 (2000) Chapter 19, Section 19.3.6.3. In a fire emergency, this deficient practice could adversely affect 54 of 54 residents. FINDINGS INCLUDE:	K 018	The kick-down hold open device on the interior passage between the soiled linen room and the laundry room was removed at the time of survey. Both areas were protected by a smoke-compartment and a 1 hour rated door to the corridor. The Environmental Service Director or his designee will monitor all doors to make sure they continue to maintain compliance	4/10/15

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K 018	Continued From page 3 On facility tour between 11:30 AM and 12:30 PM on 04/07/2015, observation revealed: A). The Interior Soiled Linen Door into the Laundry has a kick-down hold open device . This was also observed by the Director of Environmental Services (DS).	K 018	with life safety codes. This will be reviewed by the QA/PI Committee.	
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Findings include: On facility tour between 11:30 AM and 12:30 PM on 04/07/2015, observation revealed: The Door from the Activity Room to the Outside	K 022	An illuminated Exit sign was installed at the Activity room exit to ensure the exit is properly marked and maintained. The Environmental Service Director or his designee will monitor all doors to make sure they continue to maintain compliance with life safety codes. This will be reviewed by the QA/PI Committee.	4/17/15

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K 022	Continued From page 4 needs to be marked with a sign stating "NOT AN EXIT". This was also observed by the Director of Environmental Services (DS).	K 022		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 54 out of 54 residents. Findings include: On facility tour between 11:30 AM and 12:30 PM on 04/07/2015, observation revealed: #1: Laundry Interior Soiled Linen Door has a kick-down hold open device on the bottom of the door.	K 029	The kick-down hold open device on the interior door passage between the soiled linen room and the laundry room was removed at the time of survey. The Environmental Services Director or his designee will monitor all doors to make sure they continue to maintain compliance with life safety codes. This will be reviewed by the QA/PI Committee.	4/10/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/07/2015**

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 029	Continued From page 5 This deficient practice was confirmed by the Director of Environmental Services (DS) at the time of discovery.	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING **02 - 2013 LINK ADDITION** B. WING _____	**04/07/2015**

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	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 7, 2015. At the time of this survey, Building 02 of Good Samaritan Society, Mountain Lake was found to be 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) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

Since the original building and the new addition met the allowable construction type, the facility was surveyed as one building and two (2) Form CMS-2786R booklets were completed; Building 01 at Chapter 19 Existing Health Care Occupancies and Building 02 at Chapter 18 New Healthcare Occupancies.

Building 02 of Good Samaritan Society Mountain Lake consists of the 2013 Link Addition. It 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 Building 02. Building 02 is separated from an assisted living facility by a proper two-hour fire wall assembly.

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

EPOC

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

Electronically Signed | 05/04/2015

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 **02 - 2013 LINK ADDITION** B. WING _____	**04/07/2015**

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 department notification. The facility has a capacity of 54 beds and had a census of 54 at time of the survey. By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us>	K 000		