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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TZ38

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) **GO D SAMARITA SOCIETY - MOUNTAIN AKE**
(L4) **745 BASINGER MEMORIAL DRIVE**
(L5) **MOUNTAIN LAKE, MN** (L6) **56159**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 05/10/20166 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/06/206 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245549

June 6, 2016

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

Dear Ms. Reese:

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

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

Effective April 6, 2016 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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 10, 2016

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

RE: Project Number S5549026

Dear Ms. Reese:

On March 31, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 17, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 9, 2016 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 March 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 17, 2016, effective April 6, 2016 and therefore remedies outlined in our letter to you dated March 31, 2016, 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
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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245549 Y1	A. Building B. Wing Y2	4/26/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0248	Correction	ID Prefix F0282	Correction	ID Prefix F0371	Correction
Reg. # 483.15(f)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.35(i)	Completed
LSC	04/06/2016	LSC	04/06/2016	LSC	04/06/2016
ID Prefix F0431	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	04/06/2016	LSC	04/06/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	05/10/2016	03048	4/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/17/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245549 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/9/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	03/24/2016	LSC K0050	04/06/2016	LSC K0144	04/06/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0147	04/06/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 05/10/2016	SIGNATURE OF SURVEYOR 35482	DATE 5/9/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/16/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245549	A. Building 02 - 2013 LINK ADDITION B. Wing	5/9/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 04/06/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 04/06/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 5/10/2016	SIGNATURE OF SURVEYOR 35482	DATE 5/9/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/16/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TZ38

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 **03/17/2016** (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
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 04/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 04/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 31, 2016

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

RE: Project Number S5549026

Dear Ms. Reese:

On March 17, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 26, 2016, 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 April 26, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 17, 2016 (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 September 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
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 _____	03/17/2016

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 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 individualized activities for a resident who verbalized disinterest in group activities for 1 of 3 residents (R7) reviewed in the sample. Findings include: R7 had diagnoses that included: depression, traumatic brain injury with left sided paralysis, asthma, and chronic obstructive pulmonary disease.	F 248	The activity goal and plans for R7 have been reviewed and updated to reflect his current needs. Activity plans for all other residents were reviewed for possible need for additional programming and updated to reflect each resident□s needs in the area of Activities. Activity staff was educated on April 6, 2016 on the requisite of identifying the needs of residents as related to Activities,	4/6/16

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

Electronically Signed | 04/07/2016

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F 248	Continued From page 1 R7's quarterly Minimum Data Set (MDS) assessment, dated 2/25/16, identified R7 with a Brief Interview for Mental Status (BIMS) score of nine (09) indicating moderate cognition impairment. R7 was further identified as dependent on staff for locomotion and transfers and was identified with no mood or behavior indicators. R7's annual Activity Interest Data Collection Tool, dated 9/3/15, identified R7 preferred activities to included: listening to music, television, group activities, one to one activities, talking, animals, pets, clubs and organizations. R7's care plan, dated 3/3/16, identified R7 had little or no activity involvement related to no desire to participate in group activities. The care plan indicated R7 would choose to accept invitations to outdoor visits at least one time /week, weather-permitting and would actively engage in short, simple conversation during his 3 weekly one to one visits (1:1) visits. The care plan further identified R7 was able to track and answer short, simple conversation and questions, preferred Elvis and country western music, preferred watching outdoor shows, automobile restoration shows, NASCAR and motorcycle shows on the television in his room. The care plan intervention included leaving R7's television tuned to these shows when putting him in his room. During observations of R7 throughout the survey from 3/15/16 through 3/17/16 the following observations were made. On 3/15/16, at 6:42 p.m. there was a group activity occurring in the activity room. R7 was	F 248	especially lower functioning and non-verbal residents. Activity and Nursing staff were educated through a learning module completed by 4/6/16 on the importance of and how to access Care Plan interventions for all residents to ensure that all interventions are followed. The Activity Director or her designee will perform random audits on at least 2 residents per week for the next 2 months to make sure their Activity interventions are being carried out. Random audits will be done thereafter. Audit results will be reported at the monthly QAPI Committee meeting and any further action, if needed, will be determined by the interdisciplinary team. Completion date April 6, 2016.	

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F 248	Continued From page 2 observed seated in his room in his wheelchair in front of the television. The room light was off and the television was not on. On 3/16/16, at 12:11 p.m. R7 was observed seated in his wheelchair in the dayroom by the nurses station. R7 was in the dayroom alone with no activity occurring. 3/16/16 at 12:14 p.m. R7 was wheeled into his room and left seated in front of the television in his wheelchair. During the observation R7's television and room lights were off with no activity occurring in the room. R7 had his eyes closed. On 3/16/16, at 12:30 p.m. nursing assistant (NA)-E was observed to enter R7' room with a mechanical lift and transfer him to his bed. After transferring R7 into his bed NA-E left the room and turned his lights off and there was no stimulus in the room. On 3/16/16, at 2:53 p.m. R7 remained in bed with no stimulus occurring. At the time of the observation there was a group activity, piano music being played by pianist occurring in the dining room. R7 remained lying in his bed with lights off and television off until 3:48 p.m. at which time NA's-F and G entered the room and transferred R7 out of his bed with the use of a mechanical lift. NA's F and G left R7 seated in his room in front of the television with the television off and the room light off. During interview with the activity director (AD) on 3/17/16, at 9:10 a.m. the AD stated R7 did not like to socialize in large settings since his traumatic brain injury. The AD stated R7 did participate in 1 to 1 activities 2-4 times a week. The AD further stated even though R7 did not	F 248		

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F 248	Continued From page 3 always participate in activities the staff should be offering R7 to participate in activities and should have some stimulation in his room when left seated in the room. The AD stated R7 should have his television left on.	F 248		
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 plan of care for 1 of 3 residents (R7) reviewed for activities. Findings include: R7 had diagnoses that included: depression and traumatic brain injury with left sided paralysis. R7's quarterly Minimum Data Set (MDS) assessment, dated 2/25/16, identified R7 with a Brief Interview for Mental Status (BIMS) score of nine (09) indicating moderate cognition impairment. R7 was further identified as dependent on staff for locomotion and transfers and was identified with no mood or behavior indicators. R7's care plan, dated 3/3/16, identified R7 had little or no activity involvement related to no desire to participate in group activities. The care plan indicated R7 would choose to accept invitations to outdoor visits at least one time /week,	F 282	The activity goal and plans for R7 have been reviewed and updated to reflect his current needs. Activity plans for all other residents were reviewed as well. Activity and Nursing staff were educated through a learning module completed by 4/6/16 on the importance of and how to access Care Plan interventions for all residents. The Activity Director or her designee will perform random audits on at least 2 residents per week for the next 2 months to make sure their Activity interventions are being carried out. Random audits will be done thereafter. Audit results will be reported at the monthly QAPI Committee meeting and	4/6/16

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F 282	Continued From page 4 weather-permitting and would actively engage in short, simple conversation during his 3 weekly one to one visits (1:1) visits. The care plan further identified R7 was able to track and answer short, simple conversation and questions, preferred Elvis and country western music, preferred watching outdoor shows, automobile restoration shows, NASCAR and motorcycle shows on the television in his room. The care plan intervention included leaving R7's television tuned to these shows when putting him in his room. On 3/15/16, at 6:42 p.m. there was a group activity occurring in the activity room. R7 was observed seated in his room in his wheelchair in front of the television. The room light was off and the television was not on. On 3/16/16, at 12:11 p.m. R7 was observed seated in his wheelchair in the dayroom by the nurses station. R7 was in the dayroom alone with no activity occurring. 3/16/16 at 12:14 p.m. R7 was wheeled into his room and left seated in front of the television in his wheelchair. During the observation R7's television and room lights were off with no activity occurring in the room. On 3/16/16, at 12:30 p.m. nursing assistant (NA)-E was observed to transfer R7 into his bed NA-E left the room and turned his lights off and there was no stimulus in the room. On 3/16/16, at 2:53 p.m. R7 remained in bed with no stimulus occurring. At the time of the observation there was a group activity, piano music being played by pianist occurring in the dining room. R7 remained lying in his bed with lights off and television off until 3:48 p.m. at which time NA's-F and G entered the room and	F 282	any further action, if needed, will be determined by the interdisciplinary team. Completion date April 6, 2016.	

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F 282	Continued From page 5 transferred R7 out of his bed. NA's F and G left R7 seated in his room in front of the television with the television off and the room light off. During interview with the activity director (AD) on 3/17/16, at 9:10 a.m. the AD stated R7 did not like to socialize in large settings since his traumatic brain injury. The AD further stated even though R7 did not always participate in activities the staff should be offering R7 to participate in activities and should have some stimulation in his room when left seated in the room. The AD stated R7 should have his television left on.	F 282		
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, interview and document review the facility failed to store and prepare foods in a manner that maintained food safety for 53 of 53 resident's who resided in the facility and received food from the kitchen. Findings include: During initial observation of the kitchen with the	F 371	All dietary staff were re-educated on March 22, 2016 on the need for each of the following sanitary practices: 1. A pan was immediately placed under the thawing meat. The Dietary Manager and/or her designee will monitor and audit instances of meat thawing in the cooler for compliance with this process. This will be	4/6/16

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F 371	Continued From page 6 certified dietary manager (CDM) on 3/15/16, at 1:42 p.m. the following sanitary conditions were observed: 1. The facility was thawing a beef roast, that was covered with a plastic wrap, in the walk-in refrigerator with nothing beneath the thawing meat to prevent moisture from dripping onto a box of 5 pound rolls of ground beef. The outside of the packaging of the roast beef was moist and the roast was slightly thawed, soft to touch. Additionally, the thawing hamburger rolls were in a box and placed directly onto the metal shelving of the walk-in refrigerator with nothing underneath to collect the dripping moisture. During the observation the CDM stated the meat should have a tray under it to contain any thawing moisture. 2. The facility walk in-freezer had ice hanging from the cooling condenser motor that was frozen yet dripping on top of boxes of cookie dough and cake. There was nothing placed under the dripping unit to contain the moisture from the items stored underneath it. 3. The commercial grade manual can opener on the kitchen food service counter was noted to have an excess build-up of a black substance on the cutting blade and behind the cutting blade in the void space. The front of the can opener had a sticky black substance peripherally and on the cutting blade. The CDM stated the can opener was included on the cleaning schedule. During review of the kitchen cleaning schedule the schedule identified the electric can opener should be wiped down but did not include cleaning the cutting blade and area behind the	F 371	done daily for 2 weeks and then 2x weekly for the next 3 months. 2. A pan was immediately placed under the cooling condenser motor in the walk-in freezer. A pan will be left in place to catch any condensation that may occur. The pan will be checked 2x weekly and replaced with an empty pan as needed on an ongoing basis. The Dietary Manager or her designee will audit that this is present daily for 2 weeks and then 2x weekly for 3 months. 3. The blade on the can opener was immediately replaced and the entire can opener was cleaned. The can opener cleaning has been specifically placed on the cleaning schedule. The Dietary Manager or her designee will perform audits of the can opener 3x weekly for one month and then 1x weekly for one month. Audit results will be reported at the monthly QAPI Committee meeting and any further action, if needed, will be determined by the interdisciplinary team. Completion date April 6, 2016	

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F 371	Continued From page 7 blade. The CDM verified the cutting blade and area behind it was heavily soiled and that the blade had not been removed to clean the blade or the area behind it.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		4/6/16

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F 431	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper labeling and storage to ensure safe administration of medications. This had the potential to affect all residents receiving medications from the house pharmacy. Findings include: During observation of the medication pass and medication storage cart (300-400 wing) on 3/16/16, at 9:15 a.m. licensed practical nurse (LPN)-A indicated four separate medications were noted to have pharmacy labels in place that were not legible. LPN-A indicated the inability to clearly read the labels was a result of smudging of the printed labels. The four medications included: (1) R43- Combagen 1 drop (gtt) to left eye three times a day (TID),- the attached label was smudged with a large percentage of the label including the expiration date unreadable; (2) R42 - Artificial tears 1 gtt each eye twice daily (BID), the pharmacy label was not legible due to being smudged; (3) R21 - a 4 ounce bottle of liquid was in the drawer of the medication cart containing a label so severely smudged- no resident nor administration information was legible; the back label of the bottle identified the medication as: Selenium Sufide lotion 2.5% and the director of nursing (DON) identified which resident owned the shampoo; and (4) R69 - gentamycin ophthalmic gtts 0.3% with the administration order and expiration date	F 431	All drug labels were immediately checked for clarity and compliance with all required components. The drugstore was notified and all labels that were smudged or unclear were replaced. The pharmacist came to add the expiration dates to every label that did not have proper expiration dates. Discussions were held with the drugstore as to why the labels would turn dark and get smudged and the label company was contacted. The labels do react with hand sanitizer and the drugstore is looking into alternative labels. In the meantime, all labels are being covered with tape to prevent smudging. All nurses and TMAs were educated on 3/24/16 on the need to be able to read all parts of the label before administration and any medication with a label not clearly legible will not be used and the drug store will be contacted to replace the label and/or the medication. Label requirements were reviewed with all nurses and TMAs. All were instructed to allow hand sanitizer to dry prior to touching the medication label and apply gloves prior to touching the label. The Director of Nursing or her designee will audit all incoming medications for 2	

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F 431	Continued From page 9 illegible. In addition, 12 individual prescription eye medications did not have dates of expiration on the labels. Reviewed medications filled by the pharmacy which did not contain a date of expiration on the label included: 1.) Medications in the 300 -400 wing cart: The locked narcotic drawer with no expiration dates included: a. R21-was prescribed Oxycodone 10 milligrams (mg) by mouth (PO) five times daily. b. R44 Hydro-codone 5 mg-325 mg (Norco) 1 PO every (Q) morning. c. R16- Oxycodone 10 mg PO Q 4 Hours (H) as needed (PRN) d. R 28- Hydrocodone (Vicodin) 5 mg-325 mg 1 tablet PO four times per day (QID). e. R 33-Oxycodone 20 mg PO twice a day (BID) 2.) The 100-200 wing medication cart was reviewed with LPN-B and contained the following medications with no dates of expiration: a. R70- Tramadol 50 mg PO three times a day (TID) b. R24- Ibuprofen 600 mg PO TID PRN c. R33- Ibuprofen 600 mg PO Q 8 H PRN d. The locked narcotic drawer on the 100 -200 wing cart contained the following ordered medications without expiration dates: 1. R 40- Norco 1 tablet PO TID 2. R 15- Hydrocodone/APAP 5 mg-325 mg 2 tablets PO every day (QD) PRN 3. R 3- Norco 1 tablet PO TID 4. R 70- Hydrocodone/APAP 5 mg-325 mg ½ tablet PO Q 6H PRN 5. R63 - APAP/Codeine 300 mg-30 mg 1 tablet PO Q 6H PRN During interview with LPN-A on 3/16/16, at 9:30	F 431	weeks, then 15 meds per week for the next 4 weeks and random meds for the next 2 months. The Director of Nursing will audit all medications in the cart for legibility and clarity weekly for the next 2 weeks and the 10 labels per week for the next 4 weeks and then random audits for the next 2 months. Audit results will be reported at the monthly QAPI Committee meeting and any further action, if needed, will be determined by the interdisciplinary team. Completion date April 6, 2016	

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F 431	Continued From page 10	F 431		

a.m. it was verified the medications containing damaged labels should have been replaced according to facility policy and physician ordered medications obtained from the pharmacy should contain a date of expiration on the label. Both LPN- A and LPN-B were aware medications should have a date of expiration on the label, but indicated they were not aware of when the problem with the labeling began. LPN-C stated she had spoken with a pharmacy tech, (the pharmacist was not available at that time), who confirmed their new system of labeling was not printing the expiration dates on medication labels. The pharmacy was not aware of this issue until they were contacted by the facility this morning.

On 3/16/16, at 12:39 p.m. LPN-B was in attendance for observation of med room. Upon review of the refrigerator one box of multi-dose Influenza vaccine utilized for the 2015-2016 flu season was noted to be opened and doses were missing from the vial. Neither the vial nor box in which it was contained were dated as to when it had been opened. LPN-B verified the vaccine was not dated and she was unaware of when it had been opened.

The DON was interviewed on 3/16/16, at 1:26 p.m. the DON confirmed the labels should have been replaced according to facility policy. During a subsequent interview with the DON on 3/16/16, at 2:15 p.m. the DON stated the pharmacy had begun the label changes on 2/22/16. The DON stated multiple medications filled on/after 2/22/16 did not contain a date of expiration.

The pharmacist spoke with the DON on 3/16/16, at 12:00 noon and confirmed medications should have an expiration date on the label and this was

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	245549	A. BUILDING _____ B. WING _____	03/17/2016

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 431	Continued From page 11 missing on multiple medications. Review of the facility policy titled Acquisition, Receiving, Dispensing and storage of medications, Function: Nursing Services, Number II.M.8a, Issued September 2012, and last revised 12/15: All medications are packaged in accordance with the location dispensing system and state pharmacy rules. These medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied by the pharmacist or pharmacist's agent as needed.	F 431		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a safe and sanitary environment was maintained for 5 of 5 rooms (#113, #210, #302, #305, #314) reviewed with wall/ceiling damage, 1 of 1 (#205) rooms reviewed with a damaged toilet seat needing to be replaced, and 1 of 1 (#210) with "fuzzy" dusty bathroom ceiling vents in need of being cleaned. Findings include: During observation and interview with the facility maintenance director (FMD) on 3/17/016, at 1:15	F 465	The scraped areas on the wall in Room #113 and #305 were repaired, the toilet seat in Room #205 was replaced, the vent in the bathroom in Room #210 was cleaned, and the ceiling tiles in Rooms # 302 and #314 were replaced. An all-room search was done for any other rooms in need of repairs and these were also fixed. Housekeeping staff will audit all rooms daily as they are cleaning and will report any areas of concern to the maintenance	4/6/16

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 _____	03/17/2016

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 465	Continued From page 12 p.m. the following findings were noted: 1.) Room (Rm) #113 was noted to have an area approximately 12 inches x 12 inches directly behind the head rest of the recliner that had the paint scraped off and sheet rock showing. The resident in the room at the time stated she would not allow her home to have that appearance. The FMD was in agreement that this area should have been repaired. 2.) Rm #205's bathroom was noted to have a toilet seat that was cracked, and appeared to be soiled. The FMD verified this should have been replaced. 3.) Rm #210's bathroom was noted to have ceiling vents located in the bathroom which were fuzzy with dust buildup. Maintenance indicated these should have been cleaned and not allowed to build up with dust and dirt. 4.) Rm #302 was noted to have three water stains located on the ceiling above the recliner. The resident stated she had notified staff of these areas previously but that nothing had been done about it. She thought the stains had been present for at least a year. 5.) Rm #305's bathroom was noted to have the paint scraped off revealing the sheet rock along the entire wall above the base board, along the door side of the room. 6.) Rm #314's room was noted to have a large water spot, approximately 12 inches in diameter on the right side of the ceiling above the window looking outside the facility. The resident indicated she thought the spot had been present for several years and no attempts had been made to repair it. The facility maintenance director verified the above findings should have been identified and	F 465	department. The housekeeping supervisor will do an all-room search monthly for 3 months and then every 2 months thereafter to ensure all areas are addressed. Audit results will be reported at the monthly QAPI Committee meeting and any further action, if needed, will be determined by the interdisciplinary team. Completion date April 6, 2016	

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 _____	03/17/2016

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 465	Continued From page 13 repaired. He further indicated no routine rounds were conducted. Review of the Maintenance Request Sheet located at the nurses station did not include the above needed repairs. During interview with the director of nursing (DON) on 3/17/16, at 2:00 p.m. confirmed the above environmental concerns should have been reported on the Maintenance Request Sheet.	F 465		

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 _____	**03/16/2016**

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 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 March 16, 2016. 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		04/07/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2016**

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 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 55 beds and had a census of 53 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/16/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 FINDINGS INCLUDE: During Facility Inspection on March 16, 2016, between the hours of 09:00 AM and 12:30 PM, open penetrations around cables were observed in the Smoke Barriers in the 100 Wing and the 200 Wing. This was also observed by the Director of Environmental Services.	K 025	The penetrations in smoke barrier walls on 100 and 200 wings were repaired by the Director of Maintenance using Fire Barrier Sealant caulk and firestop putty. The Director of Maintenance will continue to inspect and follow up with any contractors prior to completion of work to ensure this barriers are sealed properly. Completion date: 3/24/16	3/24/16
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures	K 050		4/6/16

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 _____	**03/16/2016**

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 050	Continued From page 3 and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 FINDINGS INCLUDE: During Facility Inspection and Documentation Review on March 16, 2016,between the hours of 09:00 AM and 12:30 PM, documentation review revealed that fire drills were not conducted during the 2nd Quarter (Apr-Jun). This was also observed by the Director of Environmental Services.	K 050	The Director of Maintenance will continue to conduct the appropriate amount of fire drills required to stay in compliance with the life safety code. Audit results will be reported at the monthly QAPI Committee meeting and any further action, if needed, will be determined by the interdisciplinary team. Completion date April 6, 2016	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.	K 144		4/6/16

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 _____	**03/16/2016**

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

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K 144	Continued From page 4 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) FINDINGS INCLUDE: During Facility Inspection and Documentation Review on March 16, 2016,between the hours of 09:00 AM and 12:30 PM, the following was discovered: 1.) Documentation review revealed that the monthly generator load test was not conducted during April, May, June, and July. 2.) Documentation review revealed that the weekly generation inspection was not conducted during the period from April 1, 2015 to August 26, 2015. This was also observed by the Director of Environmental Services.	K 144	The Director of Maintenance will continue to perform both weekly and monthly generator inspections to stay in compliance with the life safety code. Audit results will be reported at the monthly QAPI Committee meeting and any further action, if needed, will be determined by the interdisciplinary team. Completion date April 6, 2016	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 FINDINGS INCLUDE: During Facility Inspection on March 16,	K 147	At the time of the survey, the electrical cord end was replaced with a new one which met the Fire Marshal□s approval. The Director of Maintenance will continue to monitor all other cords to continue to be in compliance with the life safety code.	4/6/16

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

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K 147	Continued From page 5 2016,between the hours of 09:00 AM and 12:30 PM, it was observed that the power cord to a Resident's Bed in Room 313 had wires exposed at the cord plug. This was also observed by the Director of Environmental Services.	K 147		

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 _____	**03/16/2016**

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 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 March 16, 2016. At the time of this survey, Building 02 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 18 New 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/07/2016

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 _____	**03/16/2016**

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K 000	Continued From page 1 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or 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 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 department notification. The facility has a capacity of 55 beds and had a census of 53 at time of the survey.	K 000		

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

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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 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 FINDINGS INCLUDE: During Facility Inspection and Documentation Review on March 16, 2016,between the hours of 09:00 AM and 12:30 PM, documentation review revealed that fire drills were not conducted during the 2nd	K 050	The Director of Maintenance will continue to conduct the appropriate amount of fire drills required to stay in compliance with the life safety code. Audit results will be reported at the monthly QAPI Committee meeting and any further action, if needed, will be determined by the interdisciplinary team. Completion date April 6, 2016	4/6/16

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 _____	**03/16/2016**

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

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K 050	Continued From page 3 Quarter (Apr-Jun). This was also observed by the Director of Environmental Services.	K 050		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) FINDINGS INCLUDE: During Facility Inspection and Documentation Review on March 16, 2016,between the hours of 09:00 AM and 12:30 PM, the following was discovered: 1.) Documentation review revealed that the monthly generator load test was not conducted during April, May, June, and July. 2.) Documentation review revealed that the weekly generation inspection was not conducted during the period from April 1, 2015 to August 26, 2015. This was also observed by the Director of Environmental Services.	K 144	The Director of Maintenance will continue to perform both weekly and monthly generator inspections to stay in compliance with the life safety code. Audit results will be reported at the monthly QAPI Committee meeting and any further action, if needed, will be determined by the interdisciplinary team. Completion date April 6, 2016	4/6/16

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted

March 31, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5549026

Dear Ms. Reese:

The above facility was surveyed on March 15, 2016 through March 17, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233.
You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
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
	00755	A. BUILDING: _____ B. WING _____	03/17/2016

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

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On March 15-17, 2016 surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health Health Regulation Division Licensing and Certification Mankato Place 12 Civic Center Plaza, Suite 2105 Mankato, MN 56001-7789 c/o Kathy Serie	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with	2 302		4/6/16

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2 302	Continued From page 2 this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide a description of the facility's dementia program to consumers in either written or electronic form. Findings include: During an interview with the facility social worker (SW) on 3/16/16 at 2:25 p.m. confirmed the facility had not been providing Alzheimer's/dementia training information to consumers in written or electronic form. The SW further indicated she was aware that this was required but had not implemented it yet. SUGGESTED METHOD OF CORRECTION: The facility could review the Minnesota statutes for dementia training and develop a written or electronic means of communication for the dementia training to the consumer. The facility could implement the communication into their admission process. The facility could then create and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Corrected	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care	2 565		4/6/16

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2 565	Continued From page 3 must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for 1 of 3 residents (R7) reviewed for activities. Findings include: R7 had diagnoses that included: depression and traumatic brain injury with left sided paralysis. R7's quarterly Minimum Data Set (MDS) assessment, dated 2/25/16, identified R7 with a Brief Interview for Mental Status (BIMS) score of nine (09) indicating moderate cognition impairment. R7 was further identified as dependent on staff for locomotion and transfers and was identified with no mood or behavior indicators. R7's care plan, dated 3/3/16, identified R7 had little or no activity involvement related to no desire to participate in group activities. The care plan indicated R7 would choose to accept invitations to outdoor visits at least one time /week, weather-permitting and would actively engage in short, simple conversation during his 3 weekly one to one visits (1:1) visits. The care plan further identified R7 was able to track and answer short, simple conversation and questions, preferred Elvis and country western music, preferred watching outdoor shows, automobile restoration shows, NASCAR and motorcycle shows on the television in his room. The care plan intervention included leaving R7's television tuned to these	2 565	Corrected	

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2 565	Continued From page 4 shows when putting him in his room. On 3/15/16, at 6:42 p.m. there was a group activity occurring in the activity room. R7 was observed seated in his room in his wheelchair in front of the television. The room light was off and the television was not on. On 3/16/16, at 12:11 p.m. R7 was observed seated in his wheelchair in the dayroom by the nurses station. R7 was in the dayroom alone with no activity occurring. 3/16/16 at 12:14 p.m. R7 was wheeled into his room and left seated in front of the television in his wheelchair. During the observation R7's television and room lights were off with no activity occurring in the room. On 3/16/16, at 12:30 p.m. nursing assistant (NA)-E was observed to transfer R7 into his bed NA-E left the room and turned his lights off and there was no stimulus in the room. On 3/16/16, at 2:53 p.m. R7 remained in bed with no stimulus occurring. At the time of the observation there was a group activity, piano music being played by pianist occurring in the dining room. R7 remained lying in his bed with lights off and television off until 3:48 p.m. at which time NA's-F and G entered the room and transferred R7 out of his bed. NA's F and G left R7 seated in his room in front of the television with the television off and the room light off. During interview with the activity director (AD) on 3/17/16, at 9:10 a.m. the AD stated R7 did not like to socialize in large settings since his traumatic brain injury. The AD further stated even though R7 did not always participate in activities the staff should be offering R7 to participate in activities and should have some stimulation in his	2 565		

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2 565	Continued From page 5 room when left seated in the room. The AD stated R7 should have his television left on. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or her designee could develop systems to ensure the plans of care are implemented as appropriate. The DON or her designee could educate staff on the use of the plan of care. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide individualized activities for a resident who verbalized disinterest in group activities for 1 of 3 residents (R7)	21435	Corrected	4/6/16

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21435	Continued From page 6 reviewed in the sample. Findings include: R7 had diagnoses that included: depression, traumatic brain injury with left sided paralysis, asthma, and chronic obstructive pulmonary disease. R7's quarterly Minimum Data Set (MDS) assessment, dated 2/25/16, identified R7 with a Brief Interview for Mental Status (BIMS) score of nine (09) indicating moderate cognition impairment. R7 was further identified as dependent on staff for locomotion and transfers and was identified with no mood or behavior indicators. R7's annual Activity Interest Data Collection Tool, dated 9/3/15, identified R7 preferred activities to included: listening to music, television, group activities, one to one activities, talking, animals, pets, clubs and organizations. R7's care plan, dated 3/3/16, identified R7 had little or no activity involvement related to no desire to participate in group activities. The care plan indicated R7 would choose to accept invitations to outdoor visits at least one time /week, weather-permitting and would actively engage in short, simple conversation during his 3 weekly one to one visits (1:1) visits. The care plan further identified R7 was able to track and answer short, simple conversation and questions, preferred Elvis and country western music, preferred watching outdoor shows, automobile restoration shows, NASCAR and motorcycle shows on the television in his room. The care plan intervention included leaving R7's television tuned to these shows when putting him in his room.	21435		

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21435	Continued From page 7 During observations of R7 throughout the survey from 3/15/16 through 3/17/16 the following observations were made. On 3/15/16, at 6:42 p.m. there was a group activity occurring in the activity room. R7 was observed seated in his room in his wheelchair in front of the television. The room light was off and the television was not on. On 3/16/16, at 12:11 p.m. R7 was observed seated in his wheelchair in the dayroom by the nurses station. R7 was in the dayroom alone with no activity occurring. 3/16/16 at 12:14 p.m. R7 was wheeled into his room and left seated in front of the television in his wheelchair. During the observation R7's television and room lights were off with no activity occurring in the room. R7 had his eyes closed. On 3/16/16, at 12:30 p.m. nursing assistant (NA)-E was observed to enter R7' room with a mechanical lift and transfer him to his bed. After transferring R7 into his bed NA-E left the room and turned his lights off and there was no stimulus in the room. On 3/16/16, at 2:53 p.m. R7 remained in bed with no stimulus occurring. At the time of the observation there was a group activity, piano music being played by pianist occurring in the dining room. R7 remained lying in his bed with lights off and television off until 3:48 p.m. at which time NA's-F and G entered the room and transferred R7 out of his bed with the use of a mechanical lift. NA's F and G left R7 seated in his room in front of the television with the television off and the room light off.	21435		

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21435	Continued From page 8 During interview with the activity director (AD) on 3/17/16, at 9:10 a.m. the AD stated R7 did not like to socialize in large settings since his traumatic brain injury. The AD stated R7 did participate in 1 to 1 activities 2-4 times a week. The AD further stated even though R7 did not always participate in activities the staff should be offering R7 to participate in activities and should have some stimulation in his room when left seated in the room. The AD stated R7 should have his television left on. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or Activities designee could review and revise policies and procedures related to promoting resident involvement in activities offered by the facility. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are meeting the activity needs of each resident. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper labeling and storage to ensure safe administration of medications. This had the potential to affect all residents receiving medications from the house pharmacy.	21620	Corrected	4/6/16

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21620	Continued From page 9 Findings include: During observation of the medication pass and medication storage cart (300-400 wing) on 3/16/16, at 9:15 a.m. licensed practical nurse (LPN)-A indicated four separate medications were noted to have pharmacy labels in place that were not legible. LPN-A indicated the inability to clearly read the labels was a result of smudging of the printed labels. The four medications included: (1) R43- Combagen 1 drop (gtt) to left eye three times a day (TID),- the attached label was smudged with a large percentage of the label including the expiration date unreadable; (2) R42 - Artificial tears 1 gtt each eye twice daily (BID), the pharmacy label was not legible due to being smudged; (3) R21 - a 4 ounce bottle of liquid was in the drawer of the medication cart containing a label so severely smudged- no resident nor administration information was legible; the back label of the bottle identified the medication as: Selenium Sufide lotion 2.5% and the director of nursing (DON) identified which resident owned the shampoo; and (4) R69 - gentamycin ophthalmic gtts 0.3% with the administration order and expiration date illegible. In addition, 12 individual prescription eye medications did not have dates of expiration on the labels. Reviewed medications filled by the pharmacy which did not contain a date of expiration on the label included: 1.) Medications in the 300 -400 wing cart: The locked narcotic drawer with no expiration dates included: a. R21-was prescribed Oxycodone 10 milligrams (mg) by mouth (PO) five times daily.	21620		

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21620	Continued From page 10 b. R44 Hydro-codone 5 mg-325 mg (Norco) 1 PO every (Q) morning. c. R16- Oxycodone 10 mg PO Q 4 Hours (H) as needed (PRN) d. R 28- Hydrocodone (Vicodin) 5 mg-325 mg 1 tablet PO four times per day (QID). e. R 33-Oxycodone 20 mg PO twice a day (BID) 2.) The 100-200 wing medication cart was reviewed with LPN-B and contained the following medications with no dates of expiration: a. R70- Tramadol 50 mg PO three times a day (TID) b. R24- Ibuprofen 600 mg PO TID PRN c. R33- Ibuprofen 600 mg PO Q 8 H PRN d. The locked narcotic drawer on the 100 -200 wing cart contained the following ordered medications without expiration dates: 1. R 40- Norco 1 tablet PO TID 2. R 15- Hydrocodone/APAP 5 mg-325 mg 2 tablets PO every day (QD) PRN 3. R 3- Norco 1 tablet PO TID 4. R 70- Hydrocodone/APAP 5 mg-325 mg ½ tablet PO Q 6H PRN 5. R63 - APAP/Codeine 300 mg-30 mg 1 tablet PO Q 6H PRN During interview with LPN-A on 3/16/16, at 9:30 a.m. it was verified the medications containing damaged labels should have been replaced according to facility policy and physician ordered medications obtained from the pharmacy should contain a date of expiration on the label. Both LPN- A and LPN-B were aware medications should have a date of expiration on the label, but indicated they were not aware of when the problem with the labeling began. LPN-C stated she had spoken with a pharmacy tech, (the pharmacist was not available at that time), who confirmed their new system of labeling was not printing the expiration dates on medication labels.	21620		

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21620	Continued From page 11 The pharmacy was not aware of this issue until they were contacted by the facility this morning. On 3/16/16, at 12:39 p.m. LPN-B was in attendance for observation of med room. Upon review of the refrigerator one box of multi-dose Influenza vaccine utilized for the 2015-2016 flu season was noted to be opened and doses were missing from the vial. Neither the vial nor box in which it was contained were dated as to when it had been opened. LPN-B verified the vaccine was not dated and she was unaware of when it had been opened. The DON was interviewed on 3/16/16, at 1:26 p.m. the DON confirmed the labels should have been replaced according to facility policy. During a subsequent interview with the DON on 3/16/16, at 2:15 p.m. the DON stated the pharmacy had begun the label changes on 2/22/16. The DON stated multiple medications filled on/after 2/22/16 did not contain a date of expiration. The pharmacist spoke with the DON on 3/16/16, at 12:00 noon and confirmed medications should have an expiration date on the label and this was missing on multiple medications. Review of the facility policy titled Acquisition, Receiving, Dispensing and storage of medications, Function: Nursing Services, Number II.M.8a, Issued September 2012, and last revised 12/15: All medications are packaged in accordance with the location dispensing system and state pharmacy rules. These medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied by the pharmacist or pharmacist's agent as needed.	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00755	A. BUILDING: _____ B. WING _____	03/17/2016

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

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21620	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated on the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a safe and sanitary environment was maintained for 5 of 5 rooms (#113, #210, #302, #305, #314) reviewed with wall/ceiling damage, 1 of 1 (#205) rooms reviewed with a damaged toilet seat needing to be replaced, and 1 of 1 (#210) with "fuzzy" dusty bathroom ceiling vents in need of being cleaned. Findings include: During observation and interview with the facility maintenance director (FMD) on 3/17/016, at 1:15 p.m. the following findings were noted:	21665	Corrected	4/6/16

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21665	Continued From page 13 1.) Room (Rm) #113 was noted to have an area approximately 12 inches x 12 inches directly behind the head rest of the recliner that had the paint scraped off and sheet rock showing. The resident in the room at the time stated she would not allow her home to have that appearance. The FMD was in agreement that this area should have been repaired. 2.) Rm #205's bathroom was noted to have a toilet seat that was cracked, and appeared to be soiled. The FMD verified this should have been replaced. 3.) Rm #210's bathroom was noted to have ceiling vents located in the bathroom which were fuzzy with dust buildup. Maintenance indicated these should have been cleaned and not allowed to build up with dust and dirt. 4.) Rm #302 was noted to have three water stains located on the ceiling above the recliner. The resident stated she had notified staff of these areas previously but that nothing had been done about it. She thought the stains had been present for at least a year. 5.) Rm #305's bathroom was noted to have the paint scraped off revealing the sheet rock along the entire wall above the base board, along the door side of the room. 6.) Rm #314's room was noted to have a large water spot, approximately 12 inches in diameter on the right side of the ceiling above the window looking outside the facility. The resident indicated she thought the spot had been present for several years and no attempts had been made to repair it. The facility maintenance director verified the above findings should have been identified and repaired. He further indicated no routine rounds were conducted. Review of the Maintenance	21665		

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21665	Continued From page 14 Request Sheet located at the nurses station did not include the above needed repairs. During interview with the director of nursing (DON) on 3/17/16, at 2:00 p.m. confirmed the above environmental concerns should have been reported on the Maintenance Request Sheet. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct routine periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		