DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

O TRANSMITTAL	ID: TZ38
SURVEY AGENCY	Facility ID: 00755

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 7. PROVIDER/SUPPLIER CATEGORY (D2) (L7) 8. Full Survey After C	 7 (L8) Recertification CHOW Complaint Other
6. DATE OF SURVEY	G DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): No. (b): X A. In Compliance With Program Requirements Compliance Based On: 12. Total Facility Beds 13. Total Certified Beds 15. (L18) B. Not in Compliance with Program Requirements and/or Applied Waivers: 10. THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: 12. Total Facility Beds 13. Total Certified Beds 15. (L18) B. Not in Compliance with Program Requirements and/or Applied Waivers: **Code:** A (L12)	vices Limit
14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15) 55	
(L37) (L38) (L39) (L42) (L43)	
16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):	
17. SURVEYOR SIGNATURE Date : 18. STATE SURVEY AGENCY APPROVAL	Date:
Kathryn Serie, Unit Supervisor 05/10/20166 (L19) Kamala Fiske-Downing, Health Program Representative	06/06/206 _(L20)
Kathryn Serie, Unit Supervisor 05/10/20166 (L19) Kamala Fiske-Downing, Health Program Representative PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY	06/06/206 _(L20)
(L19)	(L20)
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL RIGHTS ACT: 21. 1. Statement of Financial Solvency (HCFA-2572) 22. Ownership/Control Interest Disclosure Stmt (H	(L20)
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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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112



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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	/ISIT
	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			
<u> </u>	·			•	

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).

ITEI Y4	M	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4		DATE Y5
ID Prefix	-	Correction	ID Prefix F0282		ID Prefix		Correction
Reg. #	483.15(f)(1)	Completed	Reg. #	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
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LSC			LSC		LSC		
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	<u>.</u>	DATE	
		`KS/kfd	05/10/2016				26/2016
REVIEWS CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/17/2016				R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)		IE EA OU IT\/O	s 🗆 no

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_	ER / SUPPLIER / CLI ICATION NUMBER	A / MULTIPLE CON A. Building 01 Y1 B. Wing						Y2	DATE OF REVI 5/9/2016	ISIT Y3
	F FACILITY SAMARITAN SOCIE	ETY - MOUNTAIN L	AKE		STREET ADDR 745 BASINGER MOUNTAIN LAI	MEM	ORIAL DRI\	*		
program correcte provisio	oort is completed by n, to show those de ed and the date suc n number and the id yey report form).	ficiencies previously h corrective action	y reported was accon	on the CMS-25 oplished. Each	667, Statement of deficiency should	Deficed be f	iencies and ully identifi	d Plan of Corrected using either	ction, that have b the regulation or	LSC
ITE	EM	DATE	ITEN	Λ	DATE		ITEM		DATE	:
Y	1	Y5	Y4		Y5		Y4		Y5	
ID Prefix		Correction	ID Prefix		Correc	tion	ID Prefix	(Correc	ction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Compl	eted	Reg. #	NFPA 101	Compl	leted
LSC	K0025	03/24/2016	LSC	K0050	04/06/2	016	LSC	K0144	04/06/2	2016

Correction

Completed

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Completed

04/06/2016

Correction

Completed

Correction

Completed

Correction

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	VISIT
	A. Building 02 - 2013 LINK ADDITION			E/0/0010	
245549 _{Y1}	B. Wing	Y	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	DATE	ITEM	DATE	ITEM	DATE
Y4	Y5	Y4	Y5	Y4	Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
NFPA 101 Reg. #	Completed	Reg. #	101 Completed	Reg. #	Completed
LSC K0050	04/06/2016	LSC K0144	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	<u> </u>
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	DATE	SIGNATURE OF SURVEYOR		DATE
STATE AGENCY (REVIEWED BY INITIALS)	5/10/2016	35482		5/9/2016
REVIEWED BY	REVIEWED BY INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY (3/16/2016	COMPLETED ON		R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567)		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: TZ38 Facility ID: 00755

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1. MEDICARE/MEDICAID PROVID (L1) 245549	DER NO.	3. NAME AND AI (L3) GOOD SAM			OUNTAIN LAKE	4. TYPE OF ACTI	ON: <u>2 (</u> L8) 2. Recertification
2.STATE VENDOR OR MEDICAID	NO.	(L4) 745 BASINO	GER MEMOR	RIAL DRIV	E	3. Termination	4. CHOW
(L2) 477840500		(L5) MOUNTAIN	N LAKE, MN		(L6) 56159	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other er Complaint
	17/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	FISCAL YEAR END	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a): To (b):		_	equirements		And/Or Approved Waivers Of 2. Technical Personne		
12 Total Facility Dada	<i>EE</i> (I.19)	-	e Based On: acceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SI	7. Medical D NF) 8. Patient Ro	
12. Total Facility Beds	55 (L18) 55 (L17)	Y D. Mari G	r alab		5. Life Safety Code	9. Beds/Roor	m
13.Total Certified Beds	33 (L17)	X B. Not in Con Requirements	and/or Applied	_	* Code: B	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 55	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Pamela Manzke, I	HEE NE II		04/12/2016	(L19)	Kamala Fiske-Downing, Healt	h Program Representat	ive 04/22/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBI			MPLIANCE WITH	H CIVIL		ol Interest Disclosure Stm	
Facility is Eligible to	-				3. Both of the Abov	e:	
2. Facility is not Eligibl	e (L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	ī:	(L30)
OF PARTICIPATION 02/01/1991	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 0 01-Merger, Closure		NTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provid	der Status Change
(L27)	5 5 · 10		(L44)			00-Activ	e
(127)	B. Rescind Si	uspension Date:	(L45)				
28. TERMINATION DATE:	29). INTERMEDIARY/	/CARRIER NO.		30. REMARKS		
		00140					
	(L28)	- 		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	
·							



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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor 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

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 04/12/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE KAY ID RECULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 with the regulations has been attained in accordance with your verification. F 248 483.15(f)(1) ACTIVITIES MEET SS=D 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. STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159 PREFX MOUNTAIN LAKE, MN 56159 FROOD PROVIDERS PLAN OF CORRECTION (CEAH CHON SHOULD PROVIDERS PLAN OF CORRECTION SHOULD PROVIDE MOUNTAIN LAKE, MN 56159 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 is needs in the area of Activities. Activity staff was educated on April 6, 2016 on the requisite of dentifying the needs of residents as related to Activities.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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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 248 483.15f()(1) ACTIVITIES MEET INTERESTS/INEEDS 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 two verbalized disinterest in group activities for a resident wo verbalized disinterest in group activities for a resident wo verbalized disinterest in group activities for a resident wo verbalized disinterest in group activities for a resident wo verbalized disinterest in group activities for 1 of 3 residents (R7) reviewed in the sample. 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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE COMPLÉTION
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		of activities designed the comprehensive the physical, mental of each resident. This REQUIREMENT by: Based on observative the facility factivities for a resident in group activities for reviewed in the sand Findings include: R7 had diagnoses to traumatic brain injugasthma, and chronic	ed to meet, in accordance with assessment, the interests and I, and psychosocial well-being NT is not met as evidenced ion, interview and document alled to provide individualized ent who verbalized disinterest or 1 of 3 residents (R7) apple.		been reviewed and updated to reflecturent needs. Activity plans for all other residents reviewed for possible need for add programming and updated to reflect resident is needs in the area of Activity staff was educated on April 2016 on the requisite of identifying	s were itional ct each tivities.

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

TITLE

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) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
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F 248	R7's quarterly Miniassessment, dated Brief Interview for nine (09) indicating impairment. R7 wadependent on staff and was identified indicators. R7's annual Activity dated 9/3/15, identificated 9/3/15, identificated included: listening activities, one to opets, clubs and organization of the properties of the permitting short, simple conversation one to one visits (1) identified R7 was a simple conversation of the properties and country watching outdoors shows, NASCAR at television in his rolincluded leaving Fishows when putting observations were On 3/15/16, at 6:4:	imum Data Set (MDS) d 2/25/16, identified R7 with a Mental Status (BIMS) score of g moderate cognition as further identified as f for locomotion and transfers with no mood or behavior y Interest Data Collection Tool, tified R7 preferred activities to to music, television, group ne activities, talking, animals, ganizations. ted 3/3/16, identified R7 had nvolvement related to no desire oup activities. The care plan d choose to accept invitations to ast one time /week, y and would actively engage in ersation during his 3 weekly 1:1) visits. The care plan further able to track and answer short, on and questions, preferred shows, automobile restoration and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention and motorcycle shows on the tom. The care plan intervention	F 2	Acthin 4/0 according to the control of the control	specially lower functioning and on-verbal residents. ctivity and Nursing staff were educed a learning module comple 6/16 on the importance of and he cress Care Plan interventions for sidents to ensure that all intervente followed. The Activity Director or her designed form random audits on at least sidents per week for the next 2 make sure their Activity intervente being carried out. Random autie done thereafter. Find the activity will be reported at the control of the part of t	ted by ow to all ntions ee will 2 nonths tions dits will and e	

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F 248	observed seated in front of the television was On 3/16/16, at 12: seated in his wheen urses station. R7 no activity occurrin was wheeled into hof the television in observation R7's to off with no activity his eyes closed. On 3/16/16, at 12:3 (NA)-E was observed mechanical lift and transferring R7 into and turned his ligh stimulus in the roo On 3/16/16, at 2:50 no stimulus occurrobservation there was being played dining room. R7 relights off and televitime NA's-F and G transferred R7 out mechanical lift. NA room in front of the off and the room lights to socialize in traumatic brain injuparticipate in 1 to 1	in his room in his wheelchair in on. The room light was off and not on. In p.m. R7 was observed light in the dayroom by the was in the dayroom alone with g. 3/16/16 at 12:14 p.m. R7 his room and left seated in front his wheelchair. During the elevision and room lights were occurring in the room. R7 had at transfer him to his bed. After on his bed NA-E left the room at soff and there was no m. B p.m. R7 remained in bed with ing. At the time of the was a group activity, pianod by pianist occurring in the mained lying in his bed with sion off until 3:48 p.m. at which entered the room and of his bed with the use of a 's F and G left R7 seated in his etelevision with the television	F 24	8		

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F 248 F 282 SS=D	offering R7 to partic have some stimular seated in the room. have his television	n activities the staff should be cipate in activities and should tion in his room when left. The AD stated R7 should left on.	F 248 F 282		4/6/16
	must be provided be accordance with eacare. This REQUIREMENT by: Based on observative the facility fator 1 of 3 residents. Findings include: R7 had diagnoses traumatic brain injute R7's quarterly Minimassessment, dated Brief Interview for Mine (09) indicating impairment. R7 was dependent on staff and was identified vindicators. R7's care plan, date little or no activity into participate in gro	ded or arranged by the facility y qualified persons in ich resident's written plan of the resident's written plan of care (R7) reviewed for activities. That included: depression and ry with left sided paralysis. The resident paralysis and ry with left sided paralysis. The resident paralysis and resident paralysis and resident paralysis and resident paralysis and resident paralysis. The resident paralysis are resident paralysis and resident paralysis and resident paralysis and resident paralysis. The resident paralysis are resident paralysis and resident paralysis and resident paralysis. The care plan choose to accept invitations to the resident paralysis and resident paralysis.		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 w be done thereafter. Audit results will be reported at the monthly QAPI Committee meeting and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 282	weather-permitting short, simple conversation to one visits (1 identified R7 was a simple conversation Elvis and country watching outdoor shows, NASCAR at elevision in his roo included leaving R shows when putting On 3/15/16, at 6:42 activity occurring in observed seated in front of the television was reconstructed in his wheel nurses station. R7 no activity occurring was wheeled into hof the television in lobservation R7's teoff with no activity occurring was wheeled into hof the television in lobservation R7's teoff with no activity occurring was observed to 3/16/16, at 12:3 (NA)-E was observed NA-E left the room there was no stimulus occurring observation there was no stimulus occurring observation there was no stimulus of and television of an activity of a television of	and would actively engage in ersation during his 3 weekly: 1) visits. The care plan further ble to track and answer short, in and questions, preferred restern music, preferred hows, automobile restoration and motorcycle shows on the im. The care plan intervention 7's television tuned to these g him in his room. It p.m. there was a group the activity room. R7 was his room in his wheelchair in on. The room light was off and not on. I p.m. R7 was observed chair in the dayroom by the was in the dayroom alone with g. 3/16/16 at 12:14 p.m. R7 is room and left seated in front his wheelchair. During the elevision and room lights were occurring in the room.	F2	82	any further action, if needed, will be determined by the interdisciplinary Completion date April 6, 2016.		

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F 282 F 371 SS=F	R7 seated in his row with the television of with the television of with the television of the staff should be activities and should room when left sea R7 should have his 483.35(i) FOOD PF STORE/PREPARE. The facility must - (1) Procure food froconsidered satisfact authorities; and	of his bed. NA's F and G left om in front of the television off and the room light off. The hactivity director (AD) on m. the AD stated R7 did not arge settings since his ry. The AD further stated even always participate in activities offering R7 to participate in d have some stimulation in his ted in the room. The AD stated television left on. ROCURE, SERVE - SANITARY om sources approved or story by Federal, State or local distribute and serve food	F 28			4/6/16
	by: Based on observation review the facility factors foods in a manner to 53 of 53 resident's received food from Findings include:	NT is not met as evidenced ion, interview and document illed to store and prepare hat maintained food safety for who resided in the facility and the kitchen.		All dietary staff were re-educated of March 22, 2016 on the need for each the following sanitary practices: 1. A pan was immediately placed up the thawing meat. The Dietary Man and/or her designee will monitor an instances of meat thawing in the compliance with this process. This	nder ager d audit ooler for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 371	1:42 p.m. the follow observed: 1. The facility was to covered with a plass refrigerator with normat to prevent mobox of 5 pound rolls of the packaging of the roast was slight Additionally, the that a box and placed dof the walk-in refrigit to collect the drippin observation the CD have a tray under it moisture. 2. The facility walk from the cooling conjuments and the kitchen food seen the kitchen food seen have an excess but the cutting blade are the void space. The sticky black substate cutting blade. The common of the schedule identification of the	hawing a beef roast, that was tic wrap, in the walk-in thing beneath the thawing bisture from dripping onto a sof ground beef. The outside the roast beef was moist and thy thawed, soft to touch. The walk hawing hamburger rolls were in irectly onto the metal shelving erator with nothing underneathing moisture. During the M stated the meat should to contain any thawing in-freezer had ice hanging indenser motor that was frozen of boxes of cookie dough and othing placed under the tain the moisture from the	F 371	done daily for 2 weeks and then 22 for the next 3 months. 2. A pan was immediately placed to the cooling condenser motor in the freezer. A pan will be left in place to any condensation that may occur. Pan will be checked 2x weekly and replaced with an empty pan as need an ongoing basis. The Dietary Marker designee will audit that this is placed and then 2x week months. 3. The blade on the can opener was immediately replaced and the entire opener was cleaned. The can open cleaning has been specifically placed the cleaning schedule. The Dietary Manager or her designee will perform audits of the can opener 3x weekly one month and then 1x weekly for month. Audit results will be reported at the monthly QAPI Committee meeting any further action, if needed, will be determined by the interdisciplinary Completion date April 6, 2016	under e walk-in o catch The l eded on nager or oresent kly for 3 as e can ner eed on orm orm orm orm orm orm orn and orn one		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245549	B. WING		·····	03/	17/2016
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE		74	TREET ADDRESS, CITY, STATE, ZIP CODE 45 BASINGER MEMORIAL DRIVE IOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	area behind it was I	ge 7 rified the cutting blade and neavily soiled and that the removed to clean the blade or	F3	371			
F 431 SS=E		UGS & BIOLOGICALS	F 4	31			4/6/16
	a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order	reploy or obtain the services of ist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically					
	labeled in accordant professional princip appropriate access						
	facility must store a locked compartmen	State and Federal laws, the ll drugs and biologicals in ats under proper temperature to only authorized personnel to keys.					
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distril	ovide separately locked, I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit oution systems in which the inimal and a missing dose can					

245549 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	03/17/20	16
NAME OF PROVIDER OR SUPPLIER		
STREET ADDRESS, CITT, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE 745 BASINGER MEMORIAL DRIVE		
MOUNTAIN LAKE, MN 56159		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION OF CORRECTI	D BE COMP	(5) LETION ATE
F 431 Continued From page 8 F 431		
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: 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 All drug labels were immediately of ro clarity and compliance with all components. All drug labels were immediately of ro clarity and compliance with all components. The drugstore was notified and althat were smudged or unclear were replaced. The pharmacist came to the expiration dates to every label not have proper expiration dates. Discussions were held with the dra so why the labels were immediately of roclarity and compliance with all components. The drugstore was notified and that were replaced. The pharmacist came to the expiration dates. Discussions were held with the dra so why the labels were smudged and the label compact on takes. Discussions were held with the dra s	labels e add that did ligstore k and ny was n hand ng into liging. ed on read all ation of clearly lig store liel l with all ted to apply	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245549	B. WING _		03/	17/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 431	medications did not the labels. Reviewed pharmacy which did expiration on the la 1.) Medications in locked narcotic draincluded: a. R21-was prescril (mg) by mouth (PO b. R44 Hydro-codor every (Q) morning. c. R16- Oxycodone needed (PRN) d. R 28- Hydrocodor tablet PO four times e. R 33-Oxycodone 2.) The 100-200 wreviewed with LPN-medications with na R70- Tramadol 5 (TID) b. R24- Ibuprofen 6 d. The locked narcowing cart contained medications withou 1. R 40- Norco 1 tablets PO every da 3. R 3- Norco 1 tablets PO every da 3. R 3- Norco 1 tablets PO Q 6H F 5. R63 - APAP/Coo PO Q 6H PRN	idual prescription eye have dates of expiration on defined medications filled by the defined not contain a date of bel included: the 300 -400 wing cart: The wer with no expiration dates ped Oxycodone 10 milligrams of tive times daily. The 5 mg-325 mg (Norco) 1 PO 10 mg PO Q 4 Hours (H) as per day (QID). The 20 mg PO twice a day (BID) The and contained the following of dates of expiration: The and contained the following of dates of expiration and the following of	F 4:	weeks, then 15 meds per next 4 weeks and randor next 2 months. The Director of Nursing weeking in the cart for clarity weekly for the next 10 labels per week for the and then random audits months. Audit results will be reported monthly QAPI Committed any further action, if need determined by the interdict Completion date April 6,	will audit all or legibility and t 2 weeks and the e next 4 weeks for the next 2 rted at the e meeting and ded, will be isciplinary team.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		X3) DATE SURVEY COMPLETED 03/17/2016	
		245549	B. WING		03/	17/2016	
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	, 53		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 431	damaged labels shaccording to facility medications obtain contain a date of e LPN- A and LPN-B should have a date indicated they were problem with the lashe had spoken with pharmacist was not confirmed their new printing the expirated The pharmacy was they were contacted. On 3/16/16, at 12:3 attendance for obstreview of the refriginfluenza vaccine as season was noted missing from the view which it was contained been opened. Was not dated and had been opened. The DON was interported according to the policy of the po	the medications containing hould have been replaced a policy and physician ordered led from the pharmacy should expiration on the label. Both a were aware medications of expiration on the label, but a not aware of when the abeling began. LPN-C stated the apharmacy tech, (the stavailable at that time), who we system of labeling was not ion dates on medication labels. In an aware of this issue untiled by the facility this morning. By p.m. LPN-B was in ervation of med room. Upon erator one box of multi-dose utilized for the 2015-2016 flut to be opened and doses were ial. Neither the vial nor box in ined were dated as to when it LPN-B verified the vaccine she was unaware of when it rviewed on 3/16/16, at 1:26 firmed the labels should have ording to facility policy. During view with the DON on 3/16/16, ON stated the pharmacy had anges on 2/22/16. The DON dications filled on/after 2/22/16	F 431				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ELE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		245549	B. WING		03/17/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 465 SS=B	Receiving, Dispens medications, Functi II.M.8a, Issued Sep 12/15: All medication accordance with the and state pharmacy must be labeled accregulations. Caution instructions, as well included. New label pharmacist or pharmacist	medications. by policy titled Acquisition, ing and storage of ion: Nursing Services, Number tember 2012, and last revised ons are packaged in elocation dispensing system y rules. These medications cording to state pharmacy and accessory as the expiration date, will be els will be applied by the macist's agent as needed. AL/SANITARY/COMFORTABL Devide a safe, functional, ortable environment for	F 43		4/6/16
	by: Based on observat review the facility fa sanitary environme rooms (#113, #210, with wall/ceiling dar reviewed with a dar be replaced, and 1 bathroom ceiling ve Findings include: During observation	ion, interview and document alled to ensure a safe and nt was maintained for 5 of 5 #302, #305, #314) reviewed mage, 1 of 1 (#205) rooms maged toilet seat needing to of 1 (#210) with "fuzzy" dustyents in need of being cleaned. and interview with the facility or (FMD) on 3/17/016, at 1:15		The scraped areas on the wall in Ro #113 and #305 were repaired, the toi seat in Room #205 was replaced, the in the bathroom in Room #210 was cleaned, and the ceiling tiles in Room 302 and #314 were replaced. An all-room search was done for any other rooms in need of repairs and the were also fixed. Housekeeping staff will audit all room daily as they are cleaning and will repany areas of concern to the maintenant.	let e vent ns # nese ns

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245549	B. WING			03/1	17/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE		7	TREET ADDRESS, CITY, STATE, ZIP CODE 45 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	area approximately behind the head respaint scraped off ar resident in the room not allow her home FMD was in agreen been repaired. 2.) Rm #205's bath toilet seat that was soiled. The FMD vereplaced. 3.) Rm #210's bath ceiling vents located fuzzy with dust build these should have be to build up with dust. A) Rm #302 was not located on the ceiling resident stated she areas previously but about it. She though for at least a year. 5.) Rm #305's bath paint scraped off rethe entire wall above door side of the roof 6.) Rm #314's room water spot, approximate on the right side of looking outside the she thought the spot years and no attern it.	ndings were noted: 113 was noted to have an 12 inches x 12 inches directly st of the recliner that had the nd sheet rock showing. The n at the time stated she would to have that appearance. The nent that this area should have room was noted to have a cracked, and appeared to be wrified this should have been room was noted to have d in the bathroom which were dup. Maintenance indicated been cleaned and not allowed t and dirt. Died to have three water stains ng above the recliner. The had notified staff of these t that nothing had been done nt the stains had been present room was noted to have the vealing the sheet rock along e the base board, along the	F	165	department. The housekeeping supervisor will of all-room search monthly for 3 monthly then every 2 months thereafter to enable all areas are addressed. Audit results will be reported at the monthly QAPI Committee meeting any further action, if needed, will be determined by the interdisciplinary Completion date April 6, 2016	ensure and	

AND PLAN OF CORRECTION IDENTIFICATION NUMBE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245549	B. WING _		03	3/17/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CO 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 465	were conducted. Re Request Sheet loca not include the abor During interview wit (DON) on 3/17/16, above environment	r indicated no routine rounds eview of the Maintenance ated at the nurses station did	F 4	55		

F5549026

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245549 B WING 03/16/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 745 BASINGER MEMORIAL DRIVE **GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE MOUNTAIN LAKE, MN 56159** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, 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 (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

If continuation sheet Page 1 of 6

04/07/2016

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG 01 - Main Building 01	COMPLETED	
		245549	B. WING_		03/16/2016
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
K 000	Angela.Kappenma <mailto:angela.ka 01="" 1.="" 1995="" 2.="" 3.="" a="" actual,="" and="" basement,="" be="" building="" co="" compared="" construct="" construction="" control="" corprevent="" correct="" corridors="" defice="" deficiency="" description="" determined="" following="" for="" fully="" goo="" has="" ii(000)="" info="" is="" lake="" mus="" name="" no="" of="" one-story,="" or="" oresponsible="" original="" plan="" properties="" protected="" reoccurre="" reported="" survey.<="" td="" the="" to="" was="" which=""><td>state.mn.us hitney@state.mn.us> and n@state.mn.us ppenman@state.mn.us> PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. d Samaritan Society Mountain ted as follows: up was constructed in 1976, is pasement, is fully fire sprinkler determined to be of Type</td><td></td><td></td><td></td></mailto:angela.ka>	state.mn.us hitney@state.mn.us> and n@state.mn.us ppenman@state.mn.us> PRRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. d Samaritan Society Mountain ted as follows: up was constructed in 1976, is pasement, is fully fire sprinkler determined to be of Type			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 0 1	(X3) DATE SURVEY COMPLETED		
		245549	B. WING		03/	16/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
K 000 K 025 SS=D	Smoke barriers shalleast a one half hor constructed in according barriers shall be performed barriers shall be performed. Windowsteel frames. 8.3, 19.3.7.3, 19.3. This STANDARD is Smoke barriers shall be performed barriers shall be performed barriers.	enced by: AFETY CODE STANDARD all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke ermitted to terminate at an ws shall be protected by r by wired glass panels and 7.5 as not met as evidenced by: all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke ermitted to terminate at an ws shall be protected by r by wired glass panels and 7.5	K 000		aired by ng Fire pp putty. Il continue y of work to	3/24/16	
K 050 SS=D	During Facility Insp between the hours open penetrations in in the Smoke Barrie 200 Wing. This was also obse Environmental Serv NFPA 101 LIFE SA Fire drills include the signal and simulation conditions. Fire drill times under varying	pection on March 16, 2016, of 09:00 AM and 12:30 PM, around cables were observed ers in the 100 Wing and the	K 05			4/6/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549		RRECTION IDENTIFICATION NUMBER: A. E		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		B. WING _		03/16/2016			
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE				STREET ADDRESS, CITY, STATE, ZIP COD 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
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		K 05	The Director of Maintenance to conduct the appropriate and rills required to stay in compathe life safety code. Audit results will be reported monthly QAPI Committee meany further action, if needed, determined by the interdiscip Completion date April 6, 2016	nount of fire bliance with at the setting and will be linary team.		
	Review on March 09:00 AM and 12:30 PM, docume fire drills were not Quarter (Apr-Jun). This was also obse Environmental Ser	pection and Documentation 16, 2016,between the hours of entation review revealed that conducted during the 2nd erved by the Director of rvices.				410/40	
K 144 SS=D	Generators inspectunder load for 30 r	AFETY CODE STANDARD ted weekly and exercised minutes per month and shall be a NFPA 99 and NFPA 110.	K 14	4		4/6/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED
		B. WING		03/	03/16/2016	
	PROVIDER OR SUPPLIED AMARITAN SOCIET	Y - MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP COI 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
K 144 K 147 SS=E	3-4.4.1 and 8-4.2 110) This STANDARD Generators insperunder load for 30 in accordance with 3-4.4.1 and 8-4.2 110) FINDINGS INCLU During Facility Ins Review on March 09:00 AM and 12:30 PM, the fol 1.) Documentation monthly generator during April, May, 2.) Documentation weekly generation during the period to 2015. This was also obs Environmental Se NFPA 101 LIFE So Electrical wiring an accordance with N (NFPA 99) 18.9.1, This STANDARD Electrical wiring an accordance with N (NFPA 99) 18.9.1, This STANDARD	is not met as evidenced by: cted weekly and exercised minutes per month and shall be in NFPA 99 and NFPA 110. (NFPA 99), Chapter 6 (NFPA IDE: pection and Documentation 16, 2016,between the hours of lowing was discovered: in review revealed that the inload test was not conducted June, and July. in review revealed that the inspection was not conducted from April 1, 2015 to August 26, erved by the Director of rvices. AFETY CODE STANDARD and equipment shall be in lational Electrical Code. 9-1.2 19.9.1 is not met as evidenced by: ind equipment shall be in lational Electrical Code. 9-1.2 19.9.1	K 144	The Director of Maintenance to perform both weekly and magenerator inspections to stay compliance with the life safety. Audit results will be reported monthly QAPI Committee meany further action, if needed, determined by the interdiscipl Completion date April 6, 2016	e electrical a new one s approval. will continue continue to be	4/6/16

AND DUAN OF CODDECTION DENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245549	B. WING		03/	16/2016	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILE DEFICIENCY)	O BE	(X5) COMPLETION DATE	
K 147			K1				

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PRINTED: 04/11/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				FIPLE CONSTRUCTION NG 02 - 2013 LINK ADDITION		(X3) DATE SURVEY COMPLETED	
		245549	B. WING	B. WING		16/2016	
	PROVIDER OR SUPPLIER	' - MOUNTAIN LAKE	'	STREET ADDRESS, CITY, STATE, ZIP 745 BASINGER MEMORIAL DRIVI MOUNTAIN LAKE, MN 56159	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 000	INITIAL COMMEN	TS	ΚO	00			
1	FIRE SAFETY						
	FIRE SAFETY						
	ALLEGATION OF ODEPARTMENT'S ASSIGNATURE AT THE PAGE OF THE CM	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRS MS-2567 FORM WILL BE CATION OF COMPLIANCE.					
	ONSITE REVISIT (CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	OF AN ACCEPTABLE POC, OF YOUR FACILITY MAY B VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION	BE				
	Minnesota Departn Fire Marshal Division time of this survey, Samaritan Society to be in substantial requirements for pa Medicare/Medicaid	Survey was conducted by the nent of Public Safety, State on, on March 16, 2016. At the Building 02 of Good Mountain Lake was found respectively compliance with the articipation in the sety from Fire, and the 2000 to the safety from Fire, and th	the				
		Fire Protection Association afety Code (LSC), Chapter Occupancies.	18	EPC	10		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
	Health Care Fire In						

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.

noise and dreat, an approved plant of contestion to equipme to extensi

Electronically Signed

04/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245549				FIPLE CONSTRUCTION NG 02 - 2013 LINK ADDITION		(X3) DATE SURVEY COMPLETED	
		B. WING			03/16/2016		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP COE 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 000	445 Minnesota Stre St. Paul, MN 55101 By email to: Marian.Whitney@s <mailto:marian.wh (111)="" 02="" 02.="" 1.="" 2.="" 3.="" <mailto:angela.kap="" a="" actual,="" and="" angela.kappenmar="" assembly.="" building="" by="" co="" consists="" constr="" cor="" corr="" correct="" corridors="" defici="" deficiency="" department="" description="" detection="" facility="" fir="" following="" for="" good="" has="" height,="" ii="" in="" info="" is="" lake="" living="" mus="" n="" name="" notifica<="" o="" of="" one-story="" or="" plan="" pr="" prevent="" protected,="" reoccurre="" responsible="" s="" sleeping="" sprinkler="" td="" the="" to="" treatme="" type="" v="" which=""><td>tate.mn.us tate.mn.us itney@state.mn.us> and n@state.mn.us ppenman@state.mn.us> RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.</td><td>КО</td><td></td><td></td><td></td></mailto:marian.wh>	tate.mn.us tate.mn.us itney@state.mn.us> and n@state.mn.us ppenman@state.mn.us> RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.	КО				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		, ,		TIPLE CONSTRUCTION ING 02 - 2013 LINK ADDITION		(X3) DATE SURVEY COMPLETED	
		245549	B. WING		03/	16/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- MOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP O 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
K 000 K 050 SS=D	NOT MET as evide NFPA 101 LIFE SA Fire drills include the signal and simulation conditions. Fire drill times under varying on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are quere where drills are co 6:00 AM a coded a instead of audible at 18.7.1.2, 19.7.1.2. This STANDARD is Fire drills include the signal and simulating conditions. Fire drill times under varying on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are quere where drills are co 6:00 AM a coded a instead of audible at 18.7.1.2. FINDINGS INCLUE During Facility Inspreview on March 109:00 AM and 12:30 PM, docume	e 42 CFR, Subpart 483.70(a) is enced by: FETY CODE STANDARD The transmission of a fire alarm on of emergency fills are part of established alarms. The transmission of a fire alarm on of emergency fire alarms.	KO		amount of fire apliance with dat the neeting and d, will be iplinary team.	4/6/16	

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

PRINTED: 04/11/2016 FORM APPROVED OMB NO. 0938-0391

CLIVILI	13 FOR WILDICARE	& MEDICAID SERVICES			VID IVO.	0938-038
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION 02 - 2013 LINK ADDITION		SURVEY PLETED
		245549	B, WING		03/1	16/2016
	PROVIDER OR SUPPLIER	- MOUNTAIN LAKE	7	TREET ADDRESS, CITY, STATE, ZIP CODE 45 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 050	Environmental Serv	rved by the Director of vices.	K 050			
K 144 SS=D	Generators inspect under load for 30 m in accordance with 3-4.4.1 and 8-4.2 (No. 110) This STANDARD is Generators inspect under load for 30 m in accordance with 3-4.4.1 and 8-4.2 (No. 110) FINDINGS INCLUE During Facility Insp. Review on March 1 09:00 AM and 12:30 PM, the followant 1.) Documentation monthly generator I during April, May, J. 2.) Documentation weekly generation in during the period frozonts.	ection and Documentation 6, 2016,between the hours of wing was discovered: review revealed that the oad test was not conducted une, and July. review revealed that the nspection was not conducted om April 1, 2015 to August 26,	K 144	The Director of Maintenance will of 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 any further action, if needed, will be determined by the interdisciplinary Completion date April 6, 2016.	ontinue y e. and	4/6/16

Facility ID: 00755



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

Good Samaritan Society - Mountain Lake March 31, 2016 Page 2

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

Kumala Fiske Downing

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

PRINTED: 04/25/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00755 03/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE **GOOD SAMARITAN SOCIETY - MOUNTAIN LAK MOUNTAIN LAKE, MN 56159** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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

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

notice of assessment for non-compliance.

Minnesota Department of Health

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

TITLE

Electronically Signed

(X6) DATE 04/07/16 Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			E CONSTRUCTION		SURVEY PLETED
				A. BOILDING.			
		00755		B. WING		03/	17/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- MOLINTAIN LAK		NGER MEMO N LAKE, MN	DRIAL DRIVE 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 000	Minnesota Departm Health Regulation I Licensing and Certi Mankato Place 12 Civic Center Pla Mankato, MN 5600 c/o Kathy Serie	ur records and return ess below: nent of Health Division ification uza, Suite 2105 1-7789 44.6503 Alzheimer's o		2 000			4/6/16
	DISORDER TRAIN MN St. Statute 144 (a) If a nursing facil Alzheimer's disease or related of segregated or generated and their supervisocare. (b) Areas of requires (1) an explanation of related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic training program, the trained, the frequent topics covered.	EEASE OR RELATED IING:6503 lity serves persons wit disorders, whether in a eral unit, the facility's d ers must be trained in or ed training include: of Alzheimer's disease activities of daily living with challenging beha	a direct dementia e and g; aviors; s in the byees e basic				

Minnesota Department of Health

STATE FORM TZ3811 If continuation sheet 2 of 15

(X3) DATE SURVEY

Minnesota Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NO	JMBEK:	A. BUILDING:		COMP	LETED
		00755		B. WING		03/1	7/2016
	PROVIDER OR SUPPLIER	- MOUNTAIN LAF	745 BASII		STATE, ZIP CODE DRIAL DRIVE I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 302	Continued From pa this section.	ge 2		2 302			
	This MN Requirements by: Based on interview facility failed to provide dility's dementia p written or electronic	and document reviewing and document review idea and description of the program to consume	ew the the		Corrected		
	Findings include: During an interview (SW) on 3/16/16 at facility had not been Alzheimer's/dement consumers in writte further indicated shorequired but had no	2:25 p.m. confirmed n providing tia training informati en or electronic form e was aware that th	d the on to . The SW is was				
	SUGGESTED MET facility could review dementia training a electronic means of dementia training to could implement the admission process. and implement an a quality assurance p compliance.	the Minnesota state and develop a writter accommunication for the consumer. The accommunication in and the facility could the auditing system as p	utes for n or the facility to their nen create				
	TIME PERIOD FOR (21) days.	R CORRECTION: T	wenty-one				
2 565	MN Rule 4658.0405 Plan of Care; Use Subp. 3. Use. A co			2 565			4/6/16
		1					

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health

STATE FORM TZ3811 If continuation sheet 3 of 15

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00755	B. WING		03/1	7/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE		.,
00000	AMA DITAN COCIETY	745 RASI		DRIAL DRIVE		
GOODS	AMARITAN SOCIETY	- MOUNTAIN LAF MOUNTAI	N LAKE, MN	I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 3	2 565			
	-	l personnel involved in the				
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview and document ailed to follow the plan of care (R7) reviewed for activities.		Corrected		
	Findings include:					
	traumatic brain inju R7's quarterly Minir assessment, dated Brief Interview for M nine (09) indicating impairment. R7 was dependent on staff	that included: depression and ry with left sided paralysis. mum Data Set (MDS) 2/25/16, identified R7 with a Mental Status (BIMS) score of moderate cognition s further identified as for locomotion and transfers with no mood or behavior				
	little or no activity in to participate in gro indicated R7 would outdoor visits at leas weather-permitting short, simple conversation to one visits (1 identified R7 was a simple conversation Elvis and country watching outdoor s shows, NASCAR a television in his roo	ed 3/3/16, identified R7 had a nvolvement related to no desire up activities. The care plan choose to accept invitations to ast one time /week, and would actively engage in ersation during his 3 weekly and visits. The care plan further ble to track and answer short, and questions, preferred restern music, preferred hows, automobile restoration and motorcycle shows on the m. The care plan intervention 7's television tuned to these				

Minnesota Department of Health

STATE FORM TZ3811 If continuation sheet 4 of 15

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00755	B. WING		03/1	7/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	. 30, 1	
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AK		DRIAL DRIVE		
(VA) ID	ST V V D V D V S T A	TEMENT OF DEFICIENCIES	N LAKE, MN	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	shows when putting	him in his room.				
	activity occurring in observed seated in	p.m. there was a group the activity room. R7 was his room in his wheelchair in on. The room light was off and not on.				
	seated in his wheel nurses station. R7 v no activity occurring was wheeled into h of the television in h observation R7's te	1 p.m. R7 was observed chair in the dayroom by the was in the dayroom alone with g. 3/16/16 at 12:14 p.m. R7 is room and left seated in front his wheelchair. During the levision and room lights were occurring in the room.				
	(NA)-E was observe	0 p.m. nursing assistant ed to transfer R7 into his bed and turned his lights off and lus in the room.				
	no stimulus occurrious observation there we music being played dining room. R7 rer lights off and televis time NA's-F and G transferred R7 out of R7 seated in his room.	p.m. R7 remained in bed with ng. At the time of the vas a group activity, piano by pianist occurring in the mained lying in his bed with sion off until 3:48 p.m. at which entered the room and of his bed. NA's F and G left om in front of the television off and the room light off.				
	3/17/16, at 9:10 a.r like to socialize in la traumatic brain inju though R7 did not a the staff should be	th the activity director (AD) on m. the AD stated R7 did not arge settings since his ry. The AD further stated even always participate in activities offering R7 to participate in d have some stimulation in his				

Minnesota Department of Health

STATE FORM TZ3811 If continuation sheet 5 of 15

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00755	B. WING		03/1	7/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AK	NGER MEMO N LAKE, MN	DRIAL DRIVE I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	room when left seated in the room. The AD stated R7 should have his television left on.					
	director of nursing (develop systems to implemented as applemented	HOD OF CORRECTION: The DON) or her designee could ensure the plans of care are propriate. The DON or her cate staff on the use of the ON or her designee could systems to ensure ongoing				
	(21) days.	TOOTHIEGHOW. TWEING ONE				
21435	MN Rule 4658.0900 Recreation Program) Subp. 1 Activity and n; General	21435			4/6/16
	home must provide recreation program based on each individed strengths, and need meet the physical, right well-being of each right comprehensive rescomprehensive plant 4658.0400 and 465 provided opportunit	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and				
	by: Based on observati review the facility fa activities for a resid	ent is not met as evidenced on, interview and document illed to provide individualized ent who verbalized disinterest or 1 of 3 residents (R7)		Corrected		

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SU COMPLE	
7.1.12 1 27.11	0. 0020		A. BUILDING	:	00	
		00755	B. WING	·····	03/17/2	2016
NAME OF	PROVIDER OR SUPPLIER	STREE	TADDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	΄ - ΜΟΠΝΤΔΙΝΙΔΚ	ASINGER MEMO ITAIN LAKE, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21435	Continued From pa	age 6	21435			
	reviewed in the san	nple.				
	Findings include:	•				
	traumatic brain inju	that included: depression, iry with left sided paralysis, ic obstructive pulmonary				
	assessment, dated Brief Interview for M nine (09) indicating impairment. R7 wa dependent on staff	mum Data Set (MDS) I 2/25/16, identified R7 with a Mental Status (BIMS) score I moderate cognition Is further identified as I for locomotion and transfer I with no mood or behavior	of			
	dated 9/3/15, identi included: listening t	y Interest Data Collection To ified R7 preferred activities to music, television, group ne activities, talking, animals panizations.	0			
	little or no activity in to participate in gro indicated R7 would outdoor visits at leas weather-permitting short, simple conversation to one visits (1 identified R7 was a simple conversation Elvis and country watching outdoor s shows, NASCAR a television in his roo	and would actively engage ersation during his 3 weekly :1) visits. The care plan furtlable to track and answer shown and questions, preferred vestern music, preferred shows, automobile restoration and motorcycle shows on the om. The care plan intervention is to these the second shown and motorcycle shows on the om. The care plan intervention is to these the second shown and the second shown and the second shown are plan intervention.	s to in ner rt,			

Minnesota Department of Health

STATE FORM TZ3811 If continuation sheet 7 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP			SURVEY LETED	
		00755	B. WING		03/1	7/2016
	PROVIDER OR SUPPLIER	745 RAS		STATE, ZIP CODE DRIAL DRIVE		
GOODS	AMARITAN SOCIETY	- MOUNTAIN LAP MOUNTA	IN LAKE, MN	I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 7	21435			
	from 3/15/16 throug observations were in On 3/15/16, at 6:42	p.m. there was a group				
	observed seated in	the activity room. R7 was his room in his wheelchair in on. The room light was off and not on.				
	seated in his wheel nurses station. R7 v no activity occurring was wheeled into h of the television in h observation R7's te	1 p.m. R7 was observed chair in the dayroom by the was in the dayroom alone with g. 3/16/16 at 12:14 p.m. R7 is room and left seated in fronthis wheelchair. During the levision and room lights were occurring in the room. R7 had				
	(NA)-E was observed mechanical lift and transferring R7 into	0 p.m. nursing assistant ed to enter R7' room with a transfer him to his bed. After his bed NA-E left the room s off and there was no n.				
	no stimulus occurri observation there w music being played dining room. R7 rer lights off and televis time NA's-F and G transferred R7 out of mechanical lift. NA'	p.m. R7 remained in bed with ng. At the time of the vas a group activity, piano by pianist occurring in the mained lying in his bed with sion off until 3:48 p.m. at which entered the room and of his bed with the use of a s F and G left R7 seated in his television with the television ht off.				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00755	B. WING		03/1	7/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOLINTAIN LAK	NGER MEMO N LAKE, MN	DRIAL DRIVE I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21435	During interview with 3/17/16, at 9:10 a. Ilike to socialize in latraumatic brain injurparticipate in 1 to 1. The AD further stat always participate in offering R7 to participate in offering R7 to participate in offering R7 to participate in the room. Have his television. SUGGESTED MET director of nursing could review and reseated to promoting activities offered by nursing or designed educate staff and densure staff are me each resident.	th the activity director (AD) on m. the AD stated R7 did not arge settings since his ry. The AD stated R7 did activities 2-4 times a week. ed even though R7 did not n activities the staff should be cipate in activities and should tion in his room when left. The AD stated R7 should	21435			
21620	MN Rule 4658.1349 Drugs used in the rin accordance with	nursing home must be labeled	21620			4/6/16
	by: Based on observative review the facility fac	ent is not met as evidenced fon, interview and document alled to ensure proper labeling are safe administration of the potential to affect all medications from the house		Corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00755	B. WING		03/1	7/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AK	NGER MEMO IN LAKE, MN	DRIAL DRIVE I 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	age 9	21620			
	Findings include: During observation medication storage 3/16/16, at 9:15 a.m (LPN)-A indicated froted to have pharmot legible. LPN-A read the labels was printed labels. The (1) R43- Combage times a day (TID), smudged with a lar including the expiration (2) R42 - Artificial from (3) R21 - a 4 ouncedrawer of the medications of the bottle in the shampoo; and (4) R69 - gentamyor the administration of illegible. In addition, 12 individed in addition, 12 individed in additions in locked narcotic draincluded:	of the medication pass and e cart (300-400 wing) on m. licensed practical nurse our separate medications were macy labels in place that were indicated the inability to clearly a result of smudging of the four medications included: en 1 drop (gtt) to left eye three the attached label was ge percentage of the label ation date unreadable; tears 1 gtt each eye twice daily by label was not legible due to en bottle of liquid was in the cation cart containing a label ed-no resident nor mation was legible; the back dentified the medication as: tion 2.5% and the director of notified which resident owned be contained to the cation cart containing a label ed-no resident nor mation was legible; the back dentified the medication as: tion 2.5% and the director of notified which resident owned be contained to the date of expiration date. And the director of expiration on the decition of expiration date of the source of expiration on the director of expiration on the director of expiration date. And the director of expiration on the director of expiration date of the source of expiration on the director of expiration of expi				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00755	B. WING		03/1	7/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN I AK		DRIAL DRIVE		
040.15	CLIMMA DV CTA		N LAKE, MN		ONI	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 10	21620			
	every (Q) morning. c. R16- Oxycodone needed (PRN) d. R 28- Hydrocodo tablet PO four time. e. R 33-Oxycodone 2.) The 100-200 v reviewed with LPN- medications with no a. R70- Tramadol 5 (TID) b. R24- Ibuprofen 6 c. R33- Ibuprofen 6 d. The locked narco wing cart contained medications withou 1. R 40- Norco 1 ta 2. R 15- Hydrocod tablets PO every da 3. R 3- Norco 1 tal 4. R 70- Hydro tablet PO Q 6H F	20 mg PO twice a day (BID) ving medication cart was B and contained the following o dates of expiration: 0 mg PO three times a day 500 mg PO TID PRN 500 mg PO Q 8 H PRN 500 mg PO Q 8 H PRN 500 tic drawer on the 100 -200 I the following ordered t expiration dates: ablet PO TID 500 cone/APAP 5 mg-325 mg 2 ay (QD) PRN 501 501 501 501 500 500 500 500 500 500				
	a.m. it was verified damaged labels sh according to facility medications obtain	th LPN-A on 3/16/16, at 9:30 the medications containing ould have been replaced policy and physician ordered ed from the pharmacy should epiration on the label. Both				
	LPN- A and LPN-B should have a date indicated they were problem with the lashe had spoken with pharmacist was no confirmed their new	were aware medications of expiration on the label, but not aware of when the beling began. LPN-C stated that pharmacy tech, (the available at that time), who system of labeling was not on dates on medication labels.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00755	B. WING		03/1	7/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAK	NGER MEMO N LAKE, MN	DRIAL DRIVE 56159		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 11	21620			
	The pharmacy was not aware of this issue until they were contacted by the facility this morning.					
	attendance for obserview of the refrige Influenza vaccine useason was noted the missing from the viewhich it was contain had been opened. Was not dated and had been opened. The DON was interpum, the DON confibeen replaced according to the policy of the	9 p.m. LPN-B was in ervation of med room. Upon erator one box of multi-dose tilized for the 2015-2016 flu to be opened and doses were al. Neither the vial nor box in ned were dated as to when it LPN-B verified the vaccine she was unaware of when it viewed on 3/16/16, at 1:26 rmed the labels should have ording to facility policy. During view with the DON on 3/16/16, DN stated the pharmacy had				
	begun the label cha	anges on 2/22/16. The DON lications filled on/after 2/22/16				
	at 12:00 noon and	oke with the DON on 3/16/16, confirmed medications should date on the label and this was medications.				
	Receiving, Dispens medications, Funct II.M.8a, Issued Sep 12/15: All medicatic accordance with the and state pharmacy must be labeled acregulations. Caution instructions, as well included. New labeled acregulated. New labeled acregulations.	ion: Nursing Services, Number of tember 2012, and last revised ons are packaged in elocation dispensing system y rules. These medications cording to state pharmacy				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
			A. BUILDING.				
		00755	B. WING		03/1	7/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GOOD SAMARITAN SOCIETY - MOUNTAIN LAK 745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21620	Continued From pa	ge 12	21620				
	administrator, direct consulting pharmatic policies and proced medications. Nursing the importance of latest and discarding expension designee, along with medications on a recompliance. TIME PERIOD FOR (21) days.	THOD OF CORRECTION: The tor of nursing (DON) and cist could review and revise lures for proper storage of a staff could be educated on abeling medications properly ired medications. The DON or the pharmacist, could audit egular basis to ensure					
21665	MN Rule 4658.140	0 Physical Environment	21665			4/6/16	
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible.					
	by: Based on observation review the facility fasanitary environme rooms (#113, #210, with wall/ceiling dar reviewed with a darbe replaced, and 1 bathroom ceiling version for the companion of th	ent is not met as evidenced ion, interview and document ailed to ensure a safe and int was maintained for 5 of 5 at 302, #305, #314) reviewed mage, 1 of 1 (#205) rooms maged toilet seat needing to of 1 (#210) with "fuzzy" dusty ents in need of being cleaned. and interview with the facility or (FMD) on 3/17/016, at 1:15 indings were noted:		Corrected			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00755	B. WING		03/1	7/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	GOOD SAMARITAN SOCIETY - MOUNTAIN LAK 745 BASINGER MEMORIAL DRIVE						
		MOUNTAI	N LAKE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
21665	Continued From pa	ge 13	21665				
	area approximately behind the head respaint scraped off ar resident in the room not allow her home FMD was in agreen been repaired. 2.) Rm #205's bath toilet seat that was soiled. The FMD vereplaced. 3.) Rm #210's bath ceiling vents locate fuzzy with dust build these should have to build up with dust 4.) Rm #302 was not located on the ceiling resident stated she areas previously buabout it. She thought for at least a year. 5.) Rm #305's bath paint scraped off rethe entire wall above door side of the roof 6.) Rm #314's room water spot, approxion the right side of looking outside the she thought the spot	oted to have three water stains and above the recliner. The had notified staff of these at that nothing had been done at the stains had been present been was noted to have the vealing the sheet rock along the base board, along the					
	above findings shown repaired. He further	ance director verified the uld have been identified and indicated no routine rounds eview of the Maintenance					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:			E SURVEY IPLETED	
		00755		B. WING		03/	/17/2016	
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MOUNTAIN LAW MOUNTAIN LAKE, MN 56159							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21665	Request Sheet local not include the above the above the short (DON) on 3/17/16, above environment reported on the Mail SUGGESTED MET director of nursing (educate staff regard clean, functional and DON or designee, of maintenance and horoutine periodic audito ensure a safe, cleenvironment is main	ted at the nurses stat	ng d the ave been neet. ON: The ould f a safe, ent. The conduct frequent omelike possible.	21665				

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