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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VQ74

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00969

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245249**

2.STATE VENDOR OR MEDICAID NO.
(L2) **050318500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW**
(L4) **515 FRANKLIN STREET SOUTH**
(L5) **GLENWOOD, MN** (L6) **56334**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 01/14/14 (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/30

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, Unit Supervisor — 01/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 03/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 04/01/14 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/17/2014
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5249

On January 14, 2014 and January 10, 2014 Health and life safety code Post Certification Revisits were conducted and verifieed the faclity corrected deficiencies issued pursuant to the November 22, 2014 standard survey, effective December 31, 2013. Refer to the CMS 2567b forms for both health and life safety code.

Effective December 31, 2013, the facility is certified for 32 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5249

March 20, 2014

Mr. William Brewer, Administrator
Good Samaritan Society - Glenwood Lakeview
515 Franklin Street South
Glenwood, Minnesota 56334

Dear Mr. Brewer:

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 December 31, 2013 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 27, 2014

Mr. William Brewer, Administrator
Good Samaritan Society - Glenwood Lakeview
515 Franklin Street South
Glenwood, MN 56334

RE: Project Number S5249023

Dear Mr. Brewer:

On December 10, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 22, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 10, 2014 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 November 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 22, 2013, effective December 31, 2013 and therefore remedies outlined in our letter to you dated December 10, 2013, 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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Gail Anderson

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-332-5140 Fax: 218-332-5196

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245249	A. Building B. Wing	1/14/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0313** Reg. # **483.25(b)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/31/2013**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/31/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GA	01/27/14	28034	01/14/14
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/22/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245249	A. Building B. Wing **01 - MAIN BUILDING 01**	1/10/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **12/31/2013**	ID Prefix	Correction Completed **12/31/2013**	ID Prefix	Correction Completed **12/31/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0017		LSC K0021		LSC K0029	
ID Prefix	Correction Completed **12/31/2013**	ID Prefix	Correction Completed **12/31/2013**	ID Prefix	Correction Completed **12/31/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0038		LSC K0047		LSC K0052	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	01/27/14	28034	01/10/14
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/19/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: VQ74

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00969

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245249**
2.STATE VENDOR OR MEDICAID NO.
(L2) **050318500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW**
(L4) **515 FRANKLIN STREET SOUTH**
(L5) **GLENWOOD, MN** (L6) **56334**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/22/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/30

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mariam Thornquist, HFE NE II 12/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 01/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5249

At the time of the standard survey completed November 22, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7777

December 10, 2013

Mr. William Brewer, Administrator
Good Samaritan Society - Glenwood Lakeview
515 Franklin Street South
Glenwood, Minnesota 56334

RE: Project Number S5249023

Dear Mr. Brewer:

On November 22, 2013, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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>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:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537-3858

Telephone: (218)332-5140
Fax: (218) 332-5196

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 January 1, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 22, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal

regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	GENERAL DISCLAIMER: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of Federal and state law. For purposes of any allegation that the facility is not in substantial compliance with Federal requirements for participation, this response and plan of correction constitutes the facility's allegations of compliance in accordance with Section 7305 of the State Operations Manual.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	F278 1. Resident R18 did receive her glasses. 2. All other residents requiring the use of reading glasses will be offered to wear them and the care plans will be updated to reflect each resident's current needs. Training on the need for residents to use these glasses, if requested and care planned for, will be done prior to December 31, 2013. 3. Care plans will be developed by the DNS or designee to reflect each resident's current needs and DNS or	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William L Drewer — TITLE: Administrator — (X6) DATE: 12/19/13

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.

RECEIVED
DEC 23 2013
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the comprehensive assessment accurately reflected the vision status for 1 of 1 resident (R18) who required the use of glasses. Findings include: Review of R18's clinical record identified R18 had diagnoses which included cataracts (a clouding of the lens in the eye). The quarterly Minimum Data Set (MDS) dated 10/31/13, identified R18 was cognitively intact, utilized corrective lenses (contact lenses, glasses or magnifying glass) and with corrective lenses, adequately saw fine detail, including regular print in newspapers/books. Review of R18's Clinic Referral forms from dated 3/21/13, to 7/3/13, revealed on 5/1/13 R18 had cataract removal surgery on right eye and on 6/5/13 right cataract removal surgery was done. Review of the interdisciplnary notes from 5/7/13 to 7/23/13 revealed on 7/3/13, new glasses had been ordered for R18. The record lacked further documentation regarding R18's new glasses. During the following observations, R18 was not observed wearing glasses. On 11/19/13, at 4:25 p.m., R18 was seated in a recliner in her room, listening to a music station on the television. R18 was not wearing glasses. On 11/19/13, at 5:30	F 278	designee are to monitor to ensure ongoing compliance. Nursing staff will be reminded that those residents requiring glasses should be offered their glasses. 4. Observation audits will be done by DNS or designee to ensure that resident's who have reading glasses will be offered them to wear each day and when needed. These audits will be done 3 x a week for 4 weeks with results to QA for further recommendations. 5. Date of compliance: December 31, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 p.m., R18 was in the dining room seated at a table with 3 other residents waiting for the supper meal. R18 was not wearing glasses. On 11/21/13, at 3:17 p.m., R18 was seated in her wheel chair in her room, again listening to music. R18 was not wearing glasses. On 11/22/13, R18 was seated in a wheel chair in the doorway of her room watching the activity in the hallway. R18 was not wearing glasses. During interview on 11/19/13, at 4:25 p.m., R18 stated she did not have glasses and no longer read the newspaper because she could not see the print. R18 stated she enjoyed reading the newspaper in the past and would like to get glasses to do this activity again. During interview on 11/21/13, at 2:41 p.m. nursing assistant (NA)-A confirmed R18 did not wear glasses or other lenses to assist with seeing. She stated R18 had worn glasses prior to having cataract surgery this past summer, however, she had not worn glasses since her surgery. During interview on 11/21/13, at 3:00 p.m. registered nurses (RN)-D stated R18 had worn glasses prior to the cataract surgery this past summer. RN-D stated R18 had "20/20 vision now" and no longer needed glasses. After review of the clinical record, RN-D confirmed the note dated 7/3/13 identified new glasses had been ordered for R18. RN-D stated she thought R18 had received new glasses after the cataract surgery, but did not routinely wear them. During interview on 11/22/13, at 2:57 p.m., R18's family member(FM)-A confirmed R18 had not received new glasses since her eye surgery. He	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 3 stated R18 would like glasses again, "she has astigmatism," and stated the cataract surgery helped but she continued to need glasses to read. FM-A stated he routinely visited R18, and had not seen her wearing glasses since her cataract surgery. During interview on 11/22/13, at 1:01 p.m., NA-B confirmed she had not seen R18 wear glasses since the cataract surgery. During an interview on 11/22/13, at 3:00 p.m. the director of nursing (DON) confirmed the current MDS, confirmed R18's clinical record lacked evidence she had received new glasses after cataract surgery, and confirmed R18 did not have glasses in her room to use for reading.	F 278		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services for 1 of 1 resident (R18) who required glasses for reading.	F 313	F313 1. R18 did receive her glasses. 2. All current residents who require glasses for reading are wearing glasses for reading unless refused. Training on the need for residents to use these glasses, if requested and care planned for, will be done prior to December 31, 2013. 3. All residents admitted or residents with vision changes requiring glasses for reading are provided their glasses for reading unless refused. 4. Observation audits will be done by the DNS or designee to ensure that residents who have reading glasses are offered them to wear each day and when needed. These audits will be done 3 x a week for 4 weeks with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 4 Findings include: Review of R18's clinical record revealed R18 had diagnoses which included cataracts (a clouding of the lens in the eye). The quarterly Minimum Data Set (MDS) dated 10/31/13; identified R18 was cognitively intact, utilized corrective lenses (contact lenses, glasses or magnifying glass) and with corrective lenses, adequately saw fine detail, including regular print in newspapers/books. Review of R18's care plan, dated 11/13/13, included various interventions which included staff to provide assistance with activities of daily living, however, did not address R18's vision or need to wear glasses. Review of R18's Clinic Referral forms from dated 3/21/13, to 7/3/13, revealed on 5/1/13 R18 had cataract removal surgery on right eye and on 6/5/13 right cataract removal surgery was done. Review of the interdisciplinary notes from 5/7/13 to 7/23/13 revealed on 7/3/13, new glasses had been ordered for R18. The record lacked further documentation regarding R18's new glasses. During the following observations, R18 was not observed wearing glasses. On 11/19/13, at 4:25 p.m. R18 was seated in a recliner in her room, listening to a music station on the television. R18 was not wearing glasses. On 11/19/13, at 5:30 p.m. R18 was in the dining room seated at a table with 3 other residents waiting for the supper meal. R18 was not wearing glasses. On 11/21/13, at 3:17 p.m. R18 was seated in her wheel chair in her room, again listening to music. R18 was not wearing glasses. On 11/22/13, R18 was seated in in a wheel chair in the doorway of her room watching the activity in the hallway. R18 was not	F 313	results to QA for further recommendations. Date of compliance: December 31, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 5 wearing glasses. During an interview on 11/19/13, at 4:25 p.m., R18 stated she no longer read the newspaper because she did not have glasses to see the print. R18 stated she enjoyed reading the newspaper in the past and would like to get glasses to do this activity again. During an interview on 11/21/13, at 2:41 p.m. nursing assistant (NA)A confirmed R18 had worn glasses prior to having cataract surgery this past summer, and confirmed she had not seen R18 wear glasses after that. During interview on 11/21/13, at 3:00 p.m. registered nurses (RN)-D stated R18 had worn glasses prior to the cataract surgery this past summer. RN-D stated R18 had "20/20 vision now" and no longer needed glasses. After review of the clinical record, RN-D confirmed the note dated 7/3/13 identified new glasses had been ordered for R18. RN-D stated she thought R18 had received new glasses after the cataract surgery, but did not routinely wear them. During interview on 11/22/13, at 2:57 p.m., R18's family member(FM)-A confirmed R18 had not received new glasses since her eye surgery. He stated R18 would like glasses again, "she has astigmatism," and stated the cataract surgery helped but she continued to need glasses to read. FM-A stated he routinely visited R18, and had not seen her wearing glasses since her cataract surgery. During an interview on 11/22/13, at 1:01 p.m. NA-B confirmed she had not seen R18 wear glasses since the cataract surgery.	F 313		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 313	Continued From page 6 During an interview on 11/22/13, at 3:00 p.m. the director of nursing (DON) confirmed R18 ' s current care plan did not address vision needs and confirmed the current facility policy. The DON confirmed R18's clinical record lacked evidence she had received new glasses after cataract surgery, and confirmed R18 did not have glasses in her room to use for reading. A facility policy titled Care Plan, revised 1/09, identified residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. The policy identified comprehensive care plans would be developed to meet the individual needs of each resident.	F 313		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	F441 1. No cross contamination is occurring for residents R2, R3, R4, R5, R6, R7, R11, R12, R25, R40, and R41. Staff nurses will check the expiration date on germicidal wipes used to disinfect multi use glucometers and other multi use resident equipment before using. Discussion and training was held with night nurses on their responsibility to routinely check for expired or outdated medications and supplies. 2. All other residents requiring the use of the multi use glucometer will have the glucometer cleaned by the germicidal wipes and wipes will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
✓	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 7 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prevent the possible cross contamination of organisms with multi use glucometers (blood glucose machine) for 11 of 11 residents (R2, R3, R4, R5, R6, R7, R11, R12, R25, R40, R41) who received blood glucose testing in the facility. Findings include: Observations of the medication cart for the east and west wing was conducted on 11/20/13 at 2:18 p.m. with director of nursing (DON). In the top drawer of the medication cart, there were five individual packages of Super Sani Cloth germicidal disposable wipes laying in the drawer. The expiration date on each packet of germicidal	F 441	checked for expiration date before using. 3. DNS or designee will educate staff on the appropriate cleaning of multi use glucometers to prevent cross contamination by December 31, 2013. 4. Observation audits will be done by DNS or designee to ensure that the germicidal wipes have not expired before using and to ensure that nurses are checking expiration dates prior to using. These audits will be done 1 x a week for 4 weeks with results to QA for further recommendation. 5. Date of compliance: December 31, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 8 wipes was 12/2011. The DON verified the expired germicidal wipes and stated the wipes should not be utilized and immediately removed the wipes from the cart. Observation of the medication cart on the north wing was conducted on 11/20/13 at 2:58 p.m., with registered nurse (RN)-B. In the bottom drawer of the medication cart, there was a card board box which contained fifty individual Super Sani-Cloth germicidal disposable wipes and one individual packet laid on the bottom of the drawer. The expiration date on the germicidal wipes was dated 12/2011. RN-B and RN-C verified the facility routinely utilized the wipes to disinfect the multi use glucometers and other multi use resident equipment. RN-B confirmed the germicidal wipes were expired 2 years ago, immediately removed the wipes from the cart and threw them in the garbage. On 11/20/13, at 3:07 p.m. RN-B confirmed the facility had a multi-use blood glucose machine and that it is used for diabetic residents residing in the facility. She confirmed staff used the Super Sani-Cloth germicidal disposable wipes to disinfect the glucose machines between each resident use. RN-B also confirmed the usual facility practice was to have the night nurse routinely check for expired or outdated medications and supplies. On 11/20/13, at 3:10 p.m. RN-C confirmed the facility utilized a multi-use glucometer which was used for diabetic residents residing in the facility. She confirmed staff use the Super Sani-Cloth germicidal disposable wipes to disinfect the glucose machines after each resident.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 9 On 11/21/13, at 9:27 a.m. DON confirmed the facility had a multi-use blood glucose machine which was used for diabetic residents residing in the facility. She confirmed staff were routinely using the individual Super Sani-Cloth germicidal disposable wipes to disinfect the glucometer machine between residents and stated the expired individual wipes needed to be thrown away. During telephone interview on 12/9/13, at 2:17 p.m., the PDI customer service representative confirmed the expiration dates were used on the Super Sani Cloth wipes, and stated not to use the product after the expiration date because the company did not guarantee the potency of the product after the expiration date. Review of the undated facility policy titled Blood Glucose Machine Cleaning Procedure, identified staff were to clean the machine with sani cloths after each use. Review of the facility policy titled, Nursing Care Equipment And Supplies, revised February 2005, included supplies that are soiled, outdated, or suspected to be unsafe will not be used.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 465	F465 1. Backsplashes have been re-glued and sharp edges removed in resident rooms R2, R4, R6, R18, R22 and R31. 2. All residents have the potential to be affected by this deficient practice. 3. The Maintenance Supervisor will monthly inspect all resident sink areas to ensure that the backsplashes are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 10 Based on observation and interview, the facility failed to ensure a safe and hazard free environment for residents related to loose laminate backsplashes with sharp edges around resident sinks in 6 of 30 resident rooms. This had the potential to affect R2, R4, R6, R18, R22, and R31. Findings include: During the environmental tour with facility maintenance supervisor (MS), on 11/22/13, at 9:28 a.m., the following was observed: The resident rooms for R2, R4, R6, R18, R22, and R31 had vanity areas opposite the residents' beds which included a sink used for resident cares. A light colored, thin laminate covered the flat vanity area approximately 5 inches (in) around the sink. The same thin laminate created a backsplash 4 in. up the three walls which surrounded the sink. The edges of the backsplash were caulked in the corners, and the front edges were caulked flush with the walls at the front of the vanity. The laminate also covered the panel at the front of the vanity, which ended at knee level of a resident seated in a chair. In R2's room an inch of the front vertical edge of the right side of the thin laminate backsplash was pulled away from the wall which created a loose portion of the laminate with a sharp edge at R2's sink. In R4's room, an inch of the front vertical edge of the left side of the thin laminate backsplash was pulled away from the wall which created a loose portion of the laminate with a sharp edge at R4's sink.	F 465	firmly attached and do not have areas that could injure a resident. 4. Observation audits will be done by the Administrator or designee to ensure that backsplashes are firmly attached and would not injure residents 1 x week for 4 weeks with results reported to QA for further recommendation. Date of compliance: December 31, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 11 In R6's room, the laminate at the front panel of the sink had three 1/2 in. chips on the left side which created pointed sharp edges at the level of R6's knees if seated at the sink, and one 3-4 cm arc-shaped chip at the right side showing exposed wood under the laminate. In R18's room, the front vertical edge of the right side of the thin laminate backsplash was entirely pulled away from the wall which created a loose hanging portion of the laminate with a sharp edge at R18's sink. A box of resident toiletries containing items, which included lotion and a toothbrush, was setting on the right side of the sink vanity, behind the loose, sharp area. In R22's room, the front vertical edge of the left side of the thin laminate backsplash was entirely pulled away from the wall and the right vertical edge was halfway pulled away from the wall, these both created loose, hanging portions of the laminate with a sharp edges at R22's sink. In R31's room, the front vertical edge of the right side of the thin laminate backsplash was pulled away from the wall at the top edge which created a loose, sharp edge at R31's sink. During interview on 11/22/13 at 9:28 a.m., the MS confirmed the loose, sharp laminate on the vanity areas, and stated the sharp edges would be dangerous and should be firmly attached to the wood. MS further verified the sharp edges would create a potential for injury, especially for older residents with fragile skin. MS indicated he was not aware of the above findings and stated the usual process for maintenance problems in the facility was to use a communication log for	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 12 maintenance. If staff found an issue to fix, it was written down in a communication book and verbally communicated to the maintenance department, however there was not a policy for facility maintenance.	F 465		

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

F5249022

PRINTED: 12/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	**515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Good Samaritan Society - Glenwood Lakeview was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	GENERAL DISCLAIMER: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of Federal and state law. For purposes of any allegation that the facility is not in substantial compliance with Federal requirements for participation, this response and plan of correction constitutes the facility's allegations of compliance in accordance with Section 7305 of the State Operations Manual. POC ok JB 12-19-13 RECEIVED DEC 19 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dt: 1-1-14
Exit: 11-22-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William L Breeser — TITLE: Administrator — (X6) DATE: 12/19/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lakeview Good Samaritan Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1965, an addition was added to the north that was determined to be of Type II(111) construction. In 1985 an addition was added to the north that was determined to be of Type II(000) construction which is protected by a fire sprinkler system. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	**515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 areas open to the corridors and by the smoke barrier doors that is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations, the facility had penetrations in the corridors that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient practice could	K 017	K 017 *Step 1.* The facility will repair vertical penetrations in ceiling tiles to comply with NFPA Life Safety Code 101 (00) Section 19.3.6.2 and 8.2.3.3.1 to resist the passage of smoke and fire. *Step 2.* Completion Date: December 31, 2013. *Step 3.* The Maintenance Supervisor has replaced the tiles in the area affected. Monthly inspections of the ceiling tiles throughout the building will be made to assure that this deficient practice does not happen again.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	**515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017	Continued From page 3 affect the exiting for 10 of 32 residents, staff and visitors. In the event of a fire in this space, smoke and fire could spread into the corridor making it untenable. Findings include: On facility tour between 1:00 PM and 5:00 PM on 11/19/2013, it was observed that the facility has vertical penetrations on both sides of an abandoned door frame assemble that is located approximately midway down the North Wing corridor. There was a 2 inch by 13 inch opening on the north side of the door frame and a 4 inch by 13 inch opening on the south side of the door frame. This deficient practice was verified by the Maintenance Supervisor (GB).	K 017		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021	K 021 *Step 1.* A door stop was placed on the door in question to meet NFPA 101 (2000) Chapter 19, Section 19.2.2.2.6 and Chapter 7, Section 7.2.1.8. *Step 2.* Completion Date: December 31, 2013. *Step 3.* The Maintenance Supervisor will assure that the appropriate door stop is installed to assure that this door is in compliance with expected requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	**515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations, the facility has one of several hazardous storage area doors that was being held open by unapproved door hold devices and are not compliant with NFPA 101 (2000) Chapter 19, Section 19.2.2.2.6 and Chapter 7, Section 7.2.1.8. This deficient practice could adversely affect 4 of 32 residents, staff and visitors in a fire emergency, if the doors failed to close when required. Findings include: On facility tour between 1:00 PM and 5:00 PM on 11/19/2013, it was observed that the nurse's storage room 111, had an unapproved door hold open devices that is not interconnected with the fire alarm system which would not release upon fire alarm activation. This deficient practice was verified by the Maintenance Supervisor (GB).	K 021		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029	K 029 *Step 1.* Appropriate doors and closures will be installed to meet NFPA Life Safety Code 101 (2000 Edition) section 19.3.2.1 and NFPA 90A (99) section 3-3. A magnetic door device will be installed on the supply room door by St. Cloud Fire	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 5 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. and NFPA 90A (99) section 3-3 The following deficient practices could affect 10 of 32 residents, staff and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 1:00 PM and 5:00 PM on 11/19/2013, observations revealed the following deficient condition that are affecting 2 of several hazardous storage areas located in the facility: 1. The door for the North Wing nurse's storage room was not equipped with a door closer that is required for storage room greater than 50 square feet, 2. The North Wing nurse's storage room is connected to an office through a shared bathroom, this bathroom is only separated from the office with a hollow core door and not a 20 minute fire rated door that is not self-closing to	K 029	Equipment Company. This service was ordered on 12/18/13. A new one hour rated fire door was ordered for this room on 12/17/13. The bathroom door and frame adjacent to the north hall supply room will be removed and that opening will be filled in according to the Minnesota building and fire code by December 31, 2013. At the same time, the vent leading into this room will be removed. *Step 2.* Completion Date: December 31, 2013. *Step 3.* The Maintenance Supervisor will assure that all changes/additions to existing building structure is completed to meet appropriate standards.. Regularly, other doors will be inspected for cracks and the necessity for automatic closure devices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 6 resist the passage of smoke, 3. The HVAC vent located above the door of the North Wing nurse's storage room was not equipped with the required fire damper for HVAC vents that pass through a 1 hour fire rated assembly, 4. The nurse's storage room 111 is equipped with a 20 minute fire rated door that is split on the upper 1/3 section of the hinged side of the door which is causing the door to separates when opened. This deficient practice was verified by the Maintenance Supervisor (GB).	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d). The deficient practice could affect all 8 of 32 residents, staff and visitors. Findings include:	K 038	K038 *Step 1.* The facility shall provide signage by each locked delayed egress door to meet the requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d). Screen Prints Plus of Glenwood was hired to make this signage to read: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. *Step 2.* Completion Date: December 31, 2013 *Step 3.* The Maintenance Supervisor will assure that these signs are made and placed appropriately to meet requirements of the Life Safety Code.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	**515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 7 On facility tour between 1:00 PM and 5:00 PM on 11/19/2013, observation revealed that all required exits that have delayed egress magnetic locks on them do not have signs indicating how to activate and exit the magnetically locked delayed egress exit doors. There shall be a readily visible, durable sign in letters not less than 1 inch in height and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice was verified by the Maintenance Supervisor (GB).	K 038		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, the facility has failed to provide 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The deficient practice could affect all 8 of 32 residents, staff and visitors, if the lack of properly illuminated exit sign prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include:	K 047	K047 *Step 1.* The facility will assure that all exit lights meet NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. Two new bulbs were installed in the ~~exit sign adjacent~~ to the nurses station in the west corridor. *Step 2.* Completion Date: December 31, 2013. *Step 3.* The ~~Maintenance Supervisor~~ has replaced the deficient bulbs in said device. He will monthly (or more often) inspect all exit signage to assure that it is properly functioning.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 047	Continued From page 8 On facility tour between 1:00 PM and 5:00 PM on 11/19/2013, it was observed that the illuminated exit sign that is located in the West Wing corridor closest to the main nurse's station was in-operative due to 2 burnt out light bulbs that are located within the device. This deficient practice was verified by the Maintenance Supervisor (GB).	K 047		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and	K 052	K052 *Step 1.* The facility will install and maintain a fire alarm system so that it meets the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPAAA 72, Sections 2-3.4.5.1.2, 2-3.5.1. The two smoke detectors in the PT staff office were relocated in the PT office and meet the requirements for placement as outlined above. *Step 2.* Completion Date: December 31, 2013. *Step 3.* The Maintenance Supervisor will move these smoke detectors within the PT office so that they are more than 36 inches from the HVAC diffusers. The Maintenance Supervisor will inspect the building for any other detectors which are incorrectly placed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245249	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LAKEVIEW	**515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 9 emergency actions for the facility thus negatively affecting 8 of 32 residents, staff, and visitors of the facility. Findings include: On facility tour between 1:00 PM and 5:00 PM on 11/19/2013, observation revealed that there were 2 smoke detector located in the PT staff offices that were incorrectly installed by being placed within 36 inches of the HVAC diffusers. This deficient practice was verified by the Maintenance Supervisor (GB).	K 052		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7777

December 10, 2013

Mr. William Brewer, Administrator
Good Samaritan Society - Glenwood Lakeview
515 Franklin Street South
Glenwood, Minnesota 56334

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5249023

Dear Mr. Brewer:

The above facility was surveyed on November 19, 2013 through November 22, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537-3858

Telephone: (218)332-5140
Fax: (218) 332-5196

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

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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697
Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LA	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On November 19, 20, 21, 22, 2013, 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."	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William L Brewer	Administrator	12-19-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LA	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health 1505 Pebble Lake Road Suite 300 Fergus Falls, MN 56537 Office 218-332-5196	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary care and services for 1 of 1 resident (R18) who required glasses for reading. Findings include: Review of R18's clinical record revealed R18 had diagnoses which included cataracts (a clouding of the lens in the eye). The quarterly Minimum Data	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD L/	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 2 Set (MDS) dated 10/31/13; identified R18 was cognitively intact, utilized corrective lenses (contact lenses, glasses or magnifying glass) and with corrective lenses, adequately saw fine detail, including regular print in newspapers/books. Review of R18's care plan, dated 11/13/13, included various interventions which included staff to provide assistance with activities of daily living, however, did not address R18's vision or need to wear glasses. Review of R18's Clinic Referral forms from dated 3/21/13, to 7/3/13, revealed on 5/1/13 R18 had cataract removal surgery on right eye and on 6/5/13 right cataract removal surgery was done. Review of the interdisciplinary notes from 5/7/13 to 7/23/13 revealed on 7/3/13, new glasses had been ordered for R18. The record lacked further documentation regarding R18's new glasses. During the following observations, R18 was not observed wearing glasses. On 11/19/13, at 4:25 p.m. R18 was seated in a recliner in her room, listening to a music station on the television. R18 was not wearing glasses. On 11/19/13, at 5:30 p.m. R18 was in the dining room seated at a table with 3 other residents waiting for the supper meal. R18 was not wearing glasses. On 11/21/13, at 3:17 p.m. R18 was seated in her wheel chair in her room, again listening to music. R18 was not wearing glasses. On 11/22/13, R18 was seated in in a wheel chair in the doorway of her room watching the activity in the hallway. R18 was not wearing glasses. During an interview on 11/19/13, at 4:25 p.m., R18 stated she no longer read the newspaper because she did not have glasses to see the print. R18 stated she enjoyed reading the	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD L/	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 3 newspaper in the past and would like to get glasses to do this activity again. During an interview on 11/21/13, at 2:41 p.m. nursing assistant (NA)A confirmed R18 had worn glasses prior to having cataract surgery this past summer, and confirmed she had not seen R18 wear glasses after that. During interview on 11/21/13, at 3:00 p.m. registered nurses (RN)-D stated R18 had worn glasses prior to the cataract surgery this past summer. RN-D stated R18 had "20/20 vision now" and no longer needed glasses. After review of the clinical record, RN-D confirmed the note dated 7/3/13 identified new glasses had been ordered for R18. RN-D stated she thought R18 had received new glasses after the cataract surgery, but did not routinely wear them. During interview on 11/22/13, at 2:57 p.m., R18's family member(FM)-A confirmed R18 had not received new glasses since her eye surgery. He stated R18 would like glasses again, "she has astigmatism," and stated the cataract surgery helped but she continued to need glasses to read. FM-A stated he routinely visited R18, and had not seen her wearing glasses since her cataract surgery. During an interview on 11/22/13, at 1:01 p.m. NA-B confirmed she had not seen R18 wear glasses since the cataract surgery. During an interview on 11/22/13, at 3:00 p.m. the director of nursing (DON) confirmed R18 ' s current care plan did not address vision needs and confirmed the current facility policy. The DON confirmed R18's clinical record lacked evidence she had received new glasses after	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LA	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 555	Continued From page 4 cataract surgery, and confirmed R18 did not have glasses in her room to use for reading. A facility policy titled Care Plan, revised 1/09, identified residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. The policy identified comprehensive care plans would be developed to meet the individual needs of each resident. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop a system to ensure a care plan is developed to reflect each residents' current care needs. The DON or designee could educate all appropriate staff on the system, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 555		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by:	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LA	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 5 Based on observation, interview and document review, the facility failed to prevent the possible cross contamination of organisms with multi use glucometers (blood glucose machine) for 11 of 11 residents (R2, R3, R4, R5, R6, R7, R11, R12, R25, R40, R41) who received blood glucose testing in the facility. Findings include: Observations of the medication cart for the east and west wing was conducted on 11/20/13 at 2:18 p.m. with director of nursing (DON). In the top drawer of the medication cart, there were five individual packages of Super Sani Cloth germicidal disposable wipes laying in the drawer. The expiration date on each packet of germicidal wipes was 12/2011. The DON verified the expired germicidal wipes and stated the wipes should not be utilized and immediately removed the wipes from the cart. Observation of the medication cart on the north wing was conducted on 11/20/13 at 2:58 p.m., with registered nurse (RN)-B. In the bottom drawer of the medication cart, there was a card board box which contained fifty individual Super Sani-Cloth germicidal disposable wipes and one individual packet laid on the bottom of the drawer. The expiration date on the germicidal wipes was dated 12/2011. RN-B and RN-C verified the facility routinely utilized the wipes to disinfect the multi use glucometers and other multi use resident equipment. RN-B confirmed the germicidal wipes were expired 2 years ago, immediately removed the wipes from the cart and threw them in the garbage. On 11/20/13, at 3:07 p.m. RN-B confirmed the facility had a multi-use blood glucose machine	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD L/	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 6 and that it is used for diabetic residents residing in the facility. She confirmed staff used the Super Sani-Cloth germicidal disposable wipes to disinfect the glucose machines between each resident use. RN-B also confirmed the usual facility practice was to have the night nurse routinely check for expired or outdated medications and supplies. On 11/20/13, at 3:10 p.m. RN-C confirmed the facility utilized a multi-use glucometer which was used for diabetic residents residing in the facility. She confirmed staff use the Super Sani-Cloth germicidal disposable wipes to disinfect the glucose machines after each resident. On 11/21/13, at 9:27 a.m. DON confirmed the facility had a multi-use blood glucose machine which was used for diabetic residents residing in the facility. She confirmed staff were routinely using the individual Super Sani-Cloth germicidal disposable wipes to disinfect the glucometer machine between residents and stated the expired individual wipes needed to be thrown away. During telephone interview on 12/9/13, at 2:17 p.m., the PDI customer service representative confirmed the expiration dates were used on the Super Sani Cloth wipes, and stated not to use the product after the expiration date because the company did not guarantee the potency of the product after the expiration date. Review of the undated facility policy titled Blood Glucose Machine Cleaning Procedure, identified staff were to clean the machine with sani cloths after each use. Review of the facility policy titled, Nursing Care	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD L/	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 7 Equipment And Supplies, revised February 2005, included supplies that are soiled, outdated, or suspected to be unsafe will not be used. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on the appropriate cleaning of multiple patient use equipment to prevent cross contamination and then monitor for compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days	21375		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe and hazard free environment for residents related to loose laminate backsplashes with sharp edges around resident sinks in 6 of 30 resident rooms. This had the potential to affect R2, R4, R6, R18, R22, and R31. Findings include:	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD LA	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 8 During the environmental tour with facility maintenance supervisor (MS), on 11/22/13, at 9:28 a.m., the following was observed: The resident rooms for R2, R4, R6, R18, R22, and R31 had vanity areas opposite the residents' beds which included a sink used for resident cares. A light colored, thin laminate covered the flat vanity area approximately 5 inches (in) around the sink. The same thin laminate created a backsplash 4 in. up the three walls which surrounded the sink. The edges of the backsplash were caulked in the corners, and the front edges were caulked flush with the walls at the front of the vanity. The laminate also covered the panel at the front of the vanity, which ended at knee level of a resident seated in a chair. In R2's room an inch of the front vertical edge of the right side of the thin laminate backsplash was pulled away from the wall which created a loose portion of the laminate with a sharp edge at R2's sink. In R4's room, an inch of the front vertical edge of the left side of the thin laminate backsplash was pulled away from the wall which created a loose portion of the laminate with a sharp edge at R4's sink. In R6's room, the laminate at the front panel of the sink had three 1/2 in. chips on the left side which created pointed sharp edges at the level of R6's knees if seated at the sink, and one 3-4 cm arc-shaped chip at the right side showing exposed wood under the laminate. In R18's room, the front vertical edge of the right side of the thin laminate backsplash was entirely pulled away from the wall which created a loose	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD L/	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 9 hanging portion of the laminate with a sharp edge at R18's sink. A box of resident toiletries containing items, which included lotion and a toothbrush, was setting on the right side of the sink vanity, behind the loose, sharp area. In R22's room, the front vertical edge of the left side of the thin laminate backsplash was entirely pulled away from the wall and the right vertical edge was halfway pulled away from the wall, these both created loose, hanging portions of the laminate with a sharp edges at R22's sink. In R31's room, the front vertical edge of the right side of the thin laminate backsplash was pulled away from the wall at the top edge which created a loose, sharp edge at R31's sink. During interview on 11/22/13 at 9:28 a.m., the MS confirmed the loose, sharp laminate on the vanity areas, and stated the sharp edges would be dangerous and should be firmly attached to the wood. MS further verified the sharp edges would create a potential for injury, especially for older residents with fragile skin. MS indicated he was not aware of the above findings and stated the usual process for maintenance problems in the facility was to use a communication log for maintenance. If staff found an issue to fix, it was written down in a communication book and verbally communicated to the maintenance department, however there was not a policy for facility maintenance. SUGGESTED METHOD OF CORRECTION: The facility maintenance director could repair the vanity laminate to ensure safety and cleanliness	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00969	A. BUILDING: _____ B. WING _____	11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - GLENWOOD L/	515 FRANKLIN STREET SOUTH GLENWOOD, MN 56334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 10 for the residents. The facility maintenance director could routinely inspect all rooms for disrepair and safety concerns for residents. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21685		