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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: WROS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

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 **01/06/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (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
	35			
(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): Post Certification revisits were completed to verify correction of deficiencies issued pursuant to a standard survey completed 12/15/2014 and an FMS completed on 1/6/2015, effective 1/5/2015. Refer to the CMS 2567 for the results of this visit. Effective 1/5/2015, the facility is certified for 35 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Kim Swenson, DSFM — 01/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/08/2014 (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
04/01/1985
(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 02/23/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/11/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245278
February 11, 2015

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, Minnesota 55349

Dear Ms. Salonek:

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 January 5, 2015 the above facility is certified for or recommended for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 21, 2015

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, Minnesota 55349

RE: Project Number S5278022

Dear Ms. Salonek:

On December 15, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 23, 2015. (42 CFR 488.417 (b))

Also, CMS notified you in their letter dated December 15, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 23, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on October 23, 2014, a Federal Monitoring Survey (FMS) completed December 2, 2014 , and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our December 15, 2014 notice. The most serious deficiencies in your facility at the time of the standard survey were found 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), the most serious LSC deficiencies in your facility at the time of the FMS survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 15, 2014 the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed October 23, 2014. On January 6, 2015, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 23, 2014 and an FMS survey completed December 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 5, 2015. Based on our PCR, we have determined that your facility has corrected the

deficiencies issued pursuant to our standard survey, completed on October 23, 2014, and the FMS survey completed December 2, 2014, as of January 6, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 12, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 23, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 23, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 23, 2015, is to be rescinded.

In our letter of November 12, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 23, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 5, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245278	A. Building B. Wing	12/15/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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 **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **12/01/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/01/2014**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **12/01/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/01/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/01/2014**	ID Prefix **F0406** Reg. # **483.45(a)** LSC	Correction Completed **12/01/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/01/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	1/21/2015	10562	12/15/2014
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
10/23/2014			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245278

December 15, 2014
By Certified Mail and Facsimile

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

Dear Ms. Salonek:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: October 23, 2014

STATE SURVEY RESULTS
On October 21, 2014, a Life Safety Code survey and on October 23, 2014, a health survey were completed at Good Samaritan Society - Howard Lake by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level E, cited as follows:

- F244 -- S/S: E -- 483.15(c)(6) -- Listen/act On Group Grievance/recommendation.

The State agency advised you of the deficiency that led to this determination and provided you with a copy of the survey report (CMS-2567).

FEDERAL MONITORING SURVEY
In its notice dated November 12, 2014, the MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by December 2, 2014. Before a revisit was conducted, however, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on December 2, 2014. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level F, cited as follows:

- K18 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K25 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

- K51 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS are enclosed with this letter on form CMS-2567.

PLAN OF CORRECTION
Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Stephen Pelinski, Branch Manager
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION
The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visit. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Stephen Pelinski, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is January 23, 2015.

SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, we are imposing the following remedy:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective January 23, 2015

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective January 23, 2015 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). We are notifying Noridian Healthcare Solutions that the denial of payment for all new Medicare admissions is effective on January 23, 2015. We are

further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective January 23, 2015.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION

If your facility has not attained substantial compliance by April 23, 2015, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 23, 2015, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Howard Lake will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 23, 2015. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective January 23, 2015

If you disagree with the finding of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. **A <u>written</u> request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice.** Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

CONTACT INFORMATION

If you have any questions regarding the Federal Monitoring LSC survey, please contact Stephen Pelinski, Branch Manager, at (312) 886-5215. Stephen Pelinski's fax number is (443) 380-6716. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443)380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

Gregg Brandush
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

FMS - Life Safety Code

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245278	A. Building / B. Wing: 01 - MAIN BUILDING 01	1/6/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	12/03/2014	ID Prefix Reg. # NFPA 101 LSC K0025	12/18/2014	ID Prefix Reg. # NFPA 101 LSC K0051	01/05/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	1/21/2015	34764	1/6/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/2/2014			

QJEI22

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: WROS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

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 **10/23/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (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
X Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Carol Bode, HFE NE II 12/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 12/08/2014 (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
04/01/1985
(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 12/11/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0747

November 12, 2014

Ms. Laura Rindfleisch, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, Minnesota 55349

RE: Project Number S5278022

Dear Ms. Rindfleisch:

On October 23, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

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 December 2, 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 January 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 23, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Good Samaritan Society®
Howard Lake

413 13th Ave
Howard Lake, MN 55349

Phone: 320-543-3800
Fax: 320-543-2305
www.good-sam.com

Addendum to the Plan of Correction

F 225

4) Incident reports will be reviewed every time they occur to confirm: (1) the Administrator was immediately notified of the incident, (2) if the incident involved an alleged violation, it was immediately and appropriately reported to MDH OHFC and CEP and other officials per established procedure. The audit results will be reviewed at QA for further recommendations.

F 226

4) Incident reports will be reviewed every time they occur to confirm: (1) the Administrator was immediately notified of the incident, (2) if the incident involved an alleged violation, it was immediately and appropriately reported to MDH OHFC and CEP and other officials per established procedure. The audit results will be reviewed at QA for further recommendations.

F 244

3) To ensure timely resolution of resident council grievances, meeting minutes will be given to all appropriate department heads for timely response. The use of GSS Suggestion & Concern forms will be reintroduced to residents at the 11/26/14 resident council meeting, with additional reminders at quarterly care conferences. All other grievances will be reported to charge nurse or appropriate department head ~~for~~ timely response. From 11/24/14 – 01/30/14, Staff, residents and family members were reminded about the continued use of the GSS Suggestion & Concern forms. Call light response time will be investigated to ensure this is not a widespread issue. Additionally, at quarterly care conferences, residents will be specifically asked if they have any concerns.

4) Audits to be performed monthly x 3 on resident council meeting minutes and on all GSS Suggestion & Concern forms, with results reported to QA for further recommendation. Audits will also be performed monthly x 3 on call light response time, with results reported to QA for further recommendation.

F 441

1) Dressing changes for resident will be completed using appropriate infection control measures. Education regarding appropriate infection control measures during a dressing change was completed with all licensed nursing staff, with return demonstration.

Submitted 12/02/2014 by Laura Salonek, Administrator Laura Salonek 12/02/14

In Christ's Love, Everyone Is Someone.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ ~~MN Dept of Health~~ St.Cloud B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(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 and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	12/8/14 See addendum to POC BT, accepted	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Salenek — TITLE: Administrator — (X6) DATE: 11/24/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the administrator and state agency (SA) for 2 of 4 residents (R27, R16) reviewed for allegations of abuse. Findings include: R27's quarterly Minimum Data Set (MDS) dated 7/23/14, identified R27 had moderate cognitive impairment, required little to no physical assistance from staff for ambulation or transfers, and displayed behavioral symptoms including threatening and screaming at others. R27's care plan dated 8/7/14, indicated R27 had behavioral symptoms of difficulty getting along with other residents, and may threaten physical harm to others. R27's progress note dated 10/19/14, indicated "[Resident] had a verbal altercation with [R16]. [R27] was talking while church service was going	F 225	F 225 1) Upon notification to DNS and Administrator, the incident of alleged abuse was immediately reported to MDH OHFC (ID # 75643) and Common Entry Point. The alleged abuse was thoroughly investigated, with results reported to the Administrator and to MDH OHFC within 5 working days of the incident. 2) Current and future alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property will be reported in accordance with State law through established policies procedures.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/23/2014

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F 225	Continued From page 2 on. The other resident told him to stop talking, because this other resident wanted to listen to the service. Resident got extremely mad and was going to start a fight. He picked up a pumpkin by his recliner and was ready to throw it. He stated, 'I'll hit you, I mean it. You are a son of a bitch.' LPN [licensed practical nurse] and NA [nursing assistant] intervened. Got residents to stop and no further incidents." There was no indication this event was immediately reported to the administrator and state agency for alleged resident to resident abuse. An additional progress note dated 7/21/14, indicated R27 had been picking on another resident (R16) at the dinner meal. R27 became agitated and attempted to attack the other resident (R16) twice, but had been unsuccessful in making physical contact. An Incident Report dated 7/21/14, was submitted to state agency (SA) on 7/22/14. R27 had been picking on another resident and R16 yelled at him to stop. The nursing staff intervened, however R16 and R27 continued arguing and the charge nurse intervened. R27 got up from his seat and approached R16, but was re-directed by staff back to his chair. R27 stood up and approached R16 again, and two staff had to intervene and assisted R27 to the hallway from the dining room. R27 was assisted to his room by a NA, and stated he wanted "...to kill that son of a bitch." R16's quarterly MDS dated 8/13/14, indicated R16 had no cognitive impairment, exhibited no behavioral symptoms, and required supervision to complete most ADL's.	F 225	3) At 10/30/14 Resident Council meeting, definitions of abuse and neglect were reviewed with residents present and residents were encouraged to report immediately any concerns related to abuse, neglect, mistreatment, injuries of unknown source or misappropriation of resident property. A MN Vulnerable Adult assessment is completed for each resident upon admission, quarterly and as needed. At quarterly care conferences, residents are specifically asked if they have any concerns. In April 2014, all staff received their annual education regarding Abuse & Neglect. On 08/22/14, Licensed Nurse education was completed related to abuse, neglect (and related) policy and procedure and related reporting requirements. On 10/29/14, education was provided to certified nursing assistants and trained medication aides related to abuse, neglect (and related) policy and procedure and related reporting requirements. Further abuse, neglect (and related) education will be completed with licensed nursing staff on 11/20/14.	

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F 225	Continued From page 3 R16's care plan, dated 4/15/14, indicated the resident had a mood problem related to anxiety because of shortness of breath and agitation. R16's care plan directed staff to observe for signs and symptoms of irritability, agitation, and to report increased anger, labile mood or agitation, and feelings of being threatened by others to the health care provider as needed. R16's progress note dated 10/19/14, indicated the resident (R16) told another resident to be quiet during church service video because another resident wanted to listen and couldn't hear. The other resident (R27) got upset and was going to start a fight with him and R16 continued to defend the other resident. Staff intervened and told the residents to stop arguing. There was no indication this event was immediately reported to the administrator and state agency for alleged resident to resident abuse. During interviewed on 10/20/14, at 3:07 p.m. R16 stated there was another resident (R27) who picks on him and intimidates him. R16 stated staff was aware of his concern with the other resident and stated he, "Will take care of it myself." During interview on 10/21/14, at 2:45 p.m. NA-C stated she was not aware of any altercations or bullying between R16 and R27. During interview on 10/21/14, at 3:10 p.m. LPN-A stated she was unaware of any problems between R16 and R27. During interview on 10/21/14, at 3:24 p.m. NA-D stated she had not heard of any concerns or problems between R16 and R27.	F 225	4) Audits will be conducted on all incident reports monthly x 3 to confirm: (1) the Administrator was immediately notified of the incident, (2) if the incident involved an alleged violation, it was immediately and appropriately reported to MDH OHFC and CEP and other officials per established procedure. The audit results will be reviewed at QA for further recommendations. Completion date: December 1, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 4 When interviewed on 10/22/14, at 12:29 p.m. the director of nursing (DON) and administrator stated they both were unaware of the incident involving R27 and R16 on 10/19/14. The DON and administrator verified R27 showed intent to injure another resident (R16), and staff should have reported it to herself (the administrator) and SA. During another interview on 10/23/14, at 9:01 a.m. the DON stated R16 had been interviewed, and R16 talked to the DON about the verbal altercation with R27. DON stated R16 told her he was not afraid of R27. The DON stated the incident had been reported to the SA. A facility Abuse and Neglect policy dated 9/2013, indicated, "Alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 5 facility failed to follow their policy for ensuring allegations of abuse were immediately reported to the administrator, and state agency (SA) for 2 of 4 residents (R16, R27) reviewed for allegations of abuse. Findings include: A facility Abuse and Neglect policy, last revised 9/2013, indicated residents have the right to be free from verbal, physical and mental abuse. Residents must not be subjected to abuse by anyone, including but not limited to staff and other residents. Further, the policy indicated, "Alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency." A facility Incident Report Procedure policy, last revised 6/2014, indicated a definition of an incident as being an occurrence with or without injury, including verbal, physical, mental, or sexual abuse. Further, the policy indicated if the incident is resident-to-resident abuse, an incident report needs to be completed if any type of abuse occurred. R16's quarterly MDS, dated 8/13/14, indicated R16 had no cognitive impairment, exhibited no behavioral symptoms, and required supervision to complete most ADL's. When interviewed on 10/20/14, at 3:07 p.m., R16	F 226	**F 226** 1) Upon notification to DNS and Administrator, the incident of alleged abuse was immediately reported to MDH OHFC (ID # 75643) and Common Entry Point. The alleged abuse was thoroughly investigated, with results reported to the Administrator and to MDH OHFC within 5 working days of the incident. 2) Current and future alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property will be reported in accordance with State law through established policies procedures.	

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

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F 226	Continued From page 6 stated there was another resident who picks on him, and intimidates him. R16 stated staff was aware of the concern and, he "Will take care of it myself." R16's progress note, dated 10/19/14, indicated, "Res. [resident] told another res. to be quiet during church service video, because another lady resident wanted to listen and couldn't hear. The other resident got upset and was going to start a fight w/ him [with him]. Res. kept defending this lady resident that wanted to hear the church video. Did tell resident to stop arguing and staff would take care of it. Res. did stop talking to the other resident." R27's quarterly Minimum Data Set (MDS), dated 7/23/14, indicated R27 had moderately impaired cognition, required little to no physical assistance from staff for ambulation or transfers, and displayed behavioral symptoms (including threatening, and screaming at others). R27's progress note, dated 10/19/14, indicated, "Res (resident) had a verbal altercation w/ (with) [R16], [R27] was talking while church service was going on. The other res. told him to stop talking, because this other res. wanted to listen to the service. Res. got extremely mad and was going to start a fight. He picked up a pumpkin by his recliner and was ready to throw it. He stated, "I'll hit you, I mean it. You are a son of a bitch." LPN [licensed practical nurse] and NAR's [nursing assistant, registered] intervened. Got residents to stop and no further incidents." There was no indication the administrator and state agency were immediately notified of this allegation of resident to resident abuse.	F 226	3) At 10/30/14 Resident Council meeting, definitions of abuse and neglect were reviewed with residents present and residents were encouraged to report immediately any concerns related to abuse, neglect, mistreatment, injuries of unknown source or misappropriation of resident property. A MN Vulnerable Adult assessment is completed for each resident upon admission, quarterly and as needed. At quarterly care conferences, residents are specifically asked if they have any concerns. In April 2014, all staff received their annual education regarding Abuse & Neglect. On 08/22/14, Licensed Nurse education was completed related to abuse, neglect (and related) policy and procedure and related reporting requirements. On 10/29/14, education was provided to certified nursing assistants and trained medication aides related to abuse, neglect (and related) policy and procedure and related reporting requirements. Further abuse, neglect (and related) education will be completed with licensed nursing staff on 11/20/14.	

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	245278	A. BUILDING _____ B. WING _____	10/23/2014

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F 226	Continued From page 7 An additional progress note, dated 7/21/14, indicated R27 had been picking on another resident (R16) at the dinner meal. R27 became agitated and attempted to attack the other resident (R16) twice, but had been unsuccessful in making physical contact. An Incident Report, dated 7/21/14, which was submitted to state agency (SA) on 7/22/14. R27 had been picking on another resident and R16 yelled at him to stop. The nursing staff intervened, however R16 and R27 continued arguing requiring the charge nurse to intervene. R27 got up from his seat and approached R16, but was re-directed by staff back to his chair. R27 stood up and approached R16 again, requiring two staff to intervene to assist R27 to the hallway from the dining room. R27 was assisted to his room by nursing assistant (NA) staff, stating he wanted, "...to kill that son of a bitch." During interview on 10/21/14, at 2:45 p.m., NA-C stated she was not aware of any altercations or bullying between R16 and R27. When interviewed on 10/21/14, at 3:10 p.m., licensed practical nurse (LPN)-A stated she was unaware of any problems between the residents. When interviewed on 10/22/14, at 12:29 p.m., the director of nursing (DON) and administrator stated they both were unaware of the incident involving R27 and R16 on 10/19/14. The DON and administrator verified R27 showed intent to injure another resident (R16), and staff should have reported it to the administrator) and SA as identified by their policy.	F 226	4) Audits will be conducted on all incident reports monthly x 3 to confirm: (1) the Administrator was immediately notified of the incident, (2) if the incident involved an alleged violation, it was immediately and appropriately reported to MDH OHFC and CEP and other officials per established procedure. The audit results will be reviewed at QA for further recommendations. Completion date: December 1, 2014	

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F 226	Continued From page 8 During interview on 10/23/14, at 9:01 a.m., the DON stated R16 had just been interviewed, about the 10/19/14 allegation and he (R16) confirmed the verbal altercation happened. Further, R16 stated he was not afraid of R27, and did not feel unsafe. The DON stated the incident on 10/19/14 had now been reported to the SA.	F 226		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to respond timely to resident council grievances related to slow call light response times for 3 of 3 resident council meeting minutes which 7 residents (R11, R13, R14, R20, R22, R24, and R27) had attended. In addition, 2 residents (R31 and R2) complained of call light not currently being answered timely. Findings include: Review of the facility Resident Council meeting minutes from July through September 2014 meeting minutes were reviewed. The July 30, 2014 minutes identified seven residents (R11, R13, R14, R20, R22, R24, and R27) attended the	F 244	**F 244** 1) Facility visited and responded to all nine residents identified as having grievances via GSS Suggestion & Concern form to ensure resolution of grievances with each resident. 2) Current and future resident grievances will be responded to timely, with documentation on the GSS Suggestion & Concern form.	

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F 244	Continued From page 9 meeting. Under the Old Business section, [R22] stated, "That with the call light her room being at the end of the hallway she understands that it may take longer for staff to get down to her, depending on how busy staff are...will continue to keep call light on old business to follow up." The August 27, 2014 Resident Council minutes identified under Old Business, "Will continue to keep call light on old business to follow up. No changes but being worked out." The September 24, 2014 Resident Council meeting minutes identify under Old Business, " [R22] stated that the call light is still an issue." R31 was interviewed, on 10/21/14 at 9:41 a.m., and stated she takes a diuretic medication (used to reduce fluid in the body, often causing increased urination) and needs her call light answered quickly. R31 stated she frequently has to wait long periods before her call light is answered, and has sustained numerous incontinence episodes because of the amount of time it takes for her call light to be answered by staff. Further, R31 stated she has told the nursing assistant (NA) staff how frustrating it can be to wait for long periods before receiving help, and it continues to be a concern. R2 was interviewed on 10/22/14 at 10:30 a.m. and stated when he stays up later in the evening to watch a game or movie, he frequently has to wait for his call light to be answered. This usually takes approximately 20-40 minutes for them to come and answer my call light, to get him ready for bed. He stated all the nurses know about this, but nothing changes. R2 stated it has been going	F 244	3) To ensure timely resolution of resident council grievances, meeting minutes will be given to all appropriate department heads for timely response. The use of GSS Suggestion & Concern forms will be reintroduced to residents at the 11/26/14 resident council meeting, with additional reminders at quarterly care conferences. All other grievances will be reported to charge nurse or appropriate department head for timely response. From 11/24/14 – 01/30/14, Staff, residents and family members were reminded about the continued use of the GSS Suggestion & Concern forms. 4) Audits to be performed monthly x 3 on resident council meeting minutes and on all GSS Suggestion & Concern forms, with results reported to QA for further recommendation. Completion date: December 1, 2014	

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F 244	Continued From page 10 on for about one year, I'm tired of it, but what can I do? During Interview, on 10/23/2014 9:18 a.m., with the administrator and director of nursing (DON) the DON explained that call light response time were not being tracked by their current system. Everyone is expected to assist in answering call lights but they have no formal system of tracking call light. She stated they have not checked with residents or monitored the call lights to see if there was a problem with a specific time, or wing to determine where the problem was. The administrator stated she was unaware the lengthy call light response time was an issue from resident council for three consecutive meetings. They had talked with the nursing assistants about call lights, but had done nothing else to determine if there was a system wide problem or if there was only a specific time or wing that had more concerns than others. The administrator stated they could perform a focus audit for the entire building for call light response time for a quality improvement project but had not done anything besides talking with the nursing assistants. The DON stated she had heard some concerns about call lights from family members as well. Although lengthy call light responses were identified in the resident council meetings for the past three months, and there were current resident complaints of call lights not being answered timely and family concerns. The facility had not completed timely interventions to help resolve the grievance of long call light responses.	F 244		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	Continued From page 11 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure behavioral interventions were assessed and care planned for 1 of 5 (R25) residents, who displayed socially inappropriate behaviors. Findings include: R25's physician order sheet dated 9/12/14, identified R25 had diagnoses including senile dementia with delusional features, behavioral disturbances, anxiety, and depressive disorder.	F 280	**F280** 1) Care plan was modified to update the non-pharmacological interventions for resident's behaviors. 2) All residents that have been identified on the MDS as at risk for behaviors will have an appropriate care plan intervention(s) identified. 3) For residents who have been identified on the MDS as at risk for behaviors, their EMR PCC care plans will be reviewed at weekly At Risk meeting to ensure care plans are comprehensive and interdisciplinary with involvement by resident and family. Importance of daily documentation of behaviors and effectiveness of non-pharmacological interventions was reviewed with all nursing staff on 10/29/14 and 11/20/14. 4) Weekly audits x 4 on non-pharmacological interventions and their effectiveness, with results reported to QA for further recommendations. Completion date: December 1, 2014	

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F 280	Continued From page 12 R25's quarterly Minimum Data Set (MDS) dated 8/25/14, identified R25 had severe cognitive impairment and routinely displayed behaviors of striking out and yelling. R25's most recent Behavioral Symptoms Care Area Assessment (CAA) dated 3/12/14, indicated the R25's behaviors required immediate intervention by staff, and the facility would address the residents behaviors and interventions in the care plan. During observation on 10/20/14, at 3:30 p.m. R25 was laying in her bed sleeping with the lights out, door shut, and the curtains pulled. At 6:30 p.m., R25 was approached for interview. R25 began to yell and scream, and had a fearful expression on her face. Trained medication assistant (TMA)-A was notified R25 appeared to be upset and was yelling. TMA-A stated this was normal behavior for R25, and "Nothing really works," for R25's behavior. R25 continued to yell from her room for approximately 20 minutes. During observation on 10/21/2014, at 10:15 a.m. R25 was sitting in her wheelchair in her room, staring at the wall, and yelling. During observation on 10/21/14, at 2:52 p.m. R25 was sitting in her wheelchair in her room, staring at the wall, and yelling. During observation on 10/22/14, at 7:30 a.m. nursing assistants (NA)-A and NA-B had just assisted R25 with morning cares. As they left the room, R25 was sitting in her wheelchair yelling. When interviewed, both NA-A and NA-B stated R25 becomes upset whenever any cares are performed, and there are no specific interventions	F 280		

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F 280	Continued From page 13 staff had been instructed to use for R25 to calm her, because nothing had worked in the past. R25's care plan for behavioral issues dated 7/25/14, instructed staff, "Call Husband," if R25 is having behavioral issues. The care plan had no further interventions to direct staff on interventions to utilize for R25's behaviors/ yelling out. R25's electronic medical record progress notes reviewed from 7/25/14, to 10/23/14, did not identify what interventions staff attempted when R25 displayed behaviors, and what staff found effective in dealing with R25's behaviors. During interview on 10/23/14, at 9:30 a.m. director of nursing (DON) and registered nurse (RN)-A stated R25 had difficult behaviors, such as yelling out, due to severe cognitive impairment and inability to verbally communicate needs. DON and RN-A stated R25 did not have specific behavioral interventions included on the plan of care to instruct staff on interventions to use for R25's behaviors.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		

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F 309	Continued From page 14 by: Based on observation, interview, and document review, the facility failed to ensure 1 of 12 residents (R32) who were observed for wheelchair positioning, had adequate positioning. Findings include: R32's quarterly Minimum Data Set (MDS) dated 8/28/14, indicated R32 had moderate cognitive impairment, required extensive assistance with locomotion, and required extensive assistance with use of the wheelchair. R32 was observed on 10/21/14, at 9:19 a.m. seated in her wheelchair outside the beauty shop. R32's hands were clasped together with her arms resting on arm rests, and her elbows were extended upwards resting on the arm rests in the wheelchair, causing R32's shoulders to shrug upwards. During multiple observations, R32 was observed sitting in her wheelchair on 10/21/14, at 3:20 p.m., 10/22/14, at 9:01 a.m., and 10/23/14, at 8:50 a.m. R32 continued to have her arms resting on the arm rests of her wheelchair with her shoulders shrugged upwards. During interview on 10/23/14, at 8:59 a.m. director of rehabilitation (DOR) stated R32 was last seen by occupational therapy (OT) in December 2013. R32 was in a 16 inch hemi-height (lower sitting) wheelchair at that time, however, the facility had placed R32 in the current wheelchair because it had locking brakes on it. DOR was unsure when the 16 inch wheelchair was switched with the current wheelchair. DOR stated R32's positioning was,	F 309	**F 309** 1) OT evaluation for wheelchair positioning was done immediately for recommendations for adequate positioning. 2) All residents in wheelchairs that do not have adequate positioning will be referred to OT for evaluation. 3) All residents using wheelchairs will be assessed for adequate positioning by OT within 72 hours of admission. Quarterly and as needed, MDS RN will review all residents using wheelchairs for adequate positioning and will refer to OT as needed. Education was provided to MDS RN and Aegis therapy team lead 11/24/14, regarding this F tag and corresponding POC. 4) Random audits of 5 residents will be completed on wheelchair positioning monthly x 3, with results reported to QA committee for further recommendation. Completion date: December 1, 2014	

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F 309	Continued From page 15 "definitely not optimal," and poor positioning of the upper extremities in a wheelchair could cause neck discomfort. DOR measured R32's current wheelchair and stated it was a standard 18 inch wheelchair. R32's OT Discharge Summary dated 12/5/13, indicated R32 had been, "Currently positioned in a 16 inch w/c (wheelchair) with a standard 1 1/2 inch cushion." The Discharge Summary did not indicate any positioning concerns for R32 when using the 16 inch wheelchair. During interview on 10/23/14, at 9:03 a.m. trained medication aide (TMA)-B stated R32 had been using the current wheelchair, "As long as I can remember." TMA-B stated R32 had been given her current wheelchair because of the automatic locking brakes, and her arms sat too high because of the wheelchair arm rests. During interview on 10/23/14, at 11:15 a.m. registered nurse (RN)-B stated R32's current wheelchair size was not appropriate for the resident. RN-B stated R32 did not have optimal upper extremity positioning in her wheelchair, and nursing should have faxed the physician for orders to have her screened by therapy (OT) for poor wheelchair positioning. During interview on 10/23/14, at 1:10 p.m. the environmental director (ED) stated R32 had been given her current wheelchair because the old one had been destroyed. ED stated nursing had been updated several months ago when the wheelchairs were switched. During interview on 10/23/14, at 1:16 p.m. director of nursing (DON) stated R32 had been	F 309		

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F 309	Continued From page 16 given her current wheelchair because of the auto-locking brakes. DON stated usually nursing staff will seek therapy (OT) input on new equipment used for residents, however, they felt R32 had her old equipment replaced with a similar piece (another wheelchair), and therapy input was not needed. R32's care plan dated 9/2/14, indicated R32 had limited physical mobility, and used a wheelchair for locomotion, however, the care plan did not indicate what size nor what type of wheelchair R32 should be using to promote proper positioning although OT had evaluated R32 as requiring a smaller wheelchair. The facility policy titled Wheelchair Positioning dated 6/2012, indicated a purpose of providing proper body alignment for residents in wheelchairs. However, the policy lacked recommendations or procedures for ensuring residents upper extremities are supported or positioned correctly in a wheelchair.	F 309		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	F 406		

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F 406	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure active treatment services were provided for 1 of 1 residents (R20) with intellectual disability, whom had been assessed to require services. Findings include: R20's quarterly Minimum Data Set (MDS) dated 8/20/14, identified R20 had short and long term memory problems, and required extensive assistance with all activities of daily living (ADL) except eating. R20's Order Summary Report dated 9/25/14, identified diagnoses including down syndrome and epilepsy. During observation on 10/21/14, at 2:25 p.m. R20 was seated in the commons area playing with a decorated scarecrow. R20 was observed on 10/23/14, at 9:42 a.m. seated in his wheelchair self propelling up and down the hallways of the facility. R20's Level II Preadmission Screening for Persons with Developmental Disability or Related Conditions (PASRR) dated 7/20/10, indicated R20 had a developmental disability and required active treatment indicated by a checkmark being placed next to statement, "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." The PASRR identified R20 needed active treatment in the form of specialized instruction in order to acquire and maintain skills,	F 406	**F 406** 1) Contacted county social worker immediately and follow-up is being done per her recommendations. Resident initial assessment for active treatment and tour of outside facility occurred on 11/21/14. 2) Upon admission, all those with Level II PASRR that are found to have intellectual disability will be assessed for appropriate services. 3) All future residents admitted with intellectual disability will be referred to appropriate county social worker to ensure appropriate services. Education regarding this F tag and POC was provided to MDS RN 11/24/14. Social service designee was trained 11/24/14 on Level II PASRR requirements per F tag 406 and this POC. 4) Audits will be completed on each admission, monthly x 3 with results brought forth to QA committee for further recommendations. Completion date: December 1, 2014	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(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 406	Continued From page 18 and to prevent or decelerate regression or loss of current optimal functional status. R20's care plan dated 5/29/14, indicated R20 required set-up assistance from staff to complete dressing and eating, and physical assistance to transfer and complete bathing. The care plan lacked a focus of identifying and implementing approaches to meet R20's specialized rehabilitative of active treatment needs for intellectual disability. During interview on 10/23/14, at 10:46 a.m. nursing assistant (NA)-B stated staff sets up R20's clothing and provides reminders for him to complete dressing. NA-B stated R20 had not changed in ability since 2010, and staff had been following the same plan for years. NA-B was unaware of any other specialized services in place for R20. During interview on 10/23/14, at 9:30 a.m. registered nurse (RN)-A stated she was responsible to ensure resident PASSAR screenings were complete, and R20's last PASRR was completed in 2010. During interview on 10/23/14, at approximately 9:40 a.m. the director of nursing (DON) stated the facility activity aide, who was the social service designee as well, was responsible for R20's specialized programming, however, she resigned from the facility at the beginning of the month. DON stated R20's specialized rehabilitation needs were removed from the care plan because staff felt it was not a concern. The DON was unaware of what specialized services R20 required.	F 406		

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F 406	Continued From page 19 The social service designee was unavailable for interview. A facility policy on PASRR was requested, but none was provided.	F 406		
F 441 SS=D	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 (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.	F 441		

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F 441	Continued From page 20 (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 ensure appropriate infection control measures were completed during a dressing change for 1 of 1 resident (R2) observed during a pressure ulcer dressing change. Findings include: R2's Annual Minimum Data Set (MDS) dated 8/28/14, included diagnoses of quadriplegia (weakness in all four limbs), bilateral stage IV pressure ulcers (Full thickness skin loss with extensive destruction, or damage to muscle, bone), and required staff assistance for activities of daily living (ADL's). The pressure ulcers were locate on the right and left ischial tuberosities, which is a bony swelling on the posterior (buttocks), that bears the weight of the body sitting. R2's care plan dated 9/2/14, indicated, "Pressure ulcers will show signs of healing and remain free from infection through review date." The interventions to promote healing were to assess the pressure ulcer, monitor wound(s) weekly, and perform daily dressing changes. During observation on 10/22/14, at 9:54 a.m. R2 had just returned to his room from his shower and was lying on the bed ready for his pressure ulcer	F 441	**F441** 1) Dressing changes for resident are done using appropriate infection control measures. Education regarding appropriate infection control measures during a dressing change was completed with all licensed nursing staff, with return demonstration. 2) All current and future residents requiring dressing changes will have appropriate infection control measures during a dressing change. 3) Education regarding appropriate infection control measures during a dressing change was completed with all licensed nursing staff, with return demonstration—these education competencies will be completed by 12/01/14. 4) Two audits will be conducted per month x 3, with results reported to QA committee for further recommendation. Completion date: December 1, 2014	

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F 441	Continued From page 21	F 441		

dressing. Licensed practical nurse (LPN)-A stated she removed the dressing before his shower, and both dressings on the right and left ischial tuberosities pressure ulcers had a moderate amount of sero-sanguineous drainage with little odor. Registered Nurse (RN)-A and LPN-A then started to complete the pressure ulcer care. LPN-A laid bandages, tape, and wound cleanser onto a paper towel on top of a portable tray and recorded ulcer measurements.

RN-A cleansed and measured the pressure ulcer, located on the right and left ischial tuberosities (buttock) while the LPN-A wrote down the measurements. RN-A used her left hand on R2's buttocks to hold the wound open, so it would not collapse together so proper measurements could be obtained. She measured the wound using her right hand. The pressure ulcers measured: Left ischial tuberosity was length 2.5 centimeters (cm) x width 1.5 cm x depth 1.2 cm and undermining was 1.2 cm from 8:00-3:00 o'clock, with no tunneling. RN-A measured R2's right ischial tuberosity, which was approximately 8 inches from the left, again holding the buttocks with her left hand to prevent the ulcer from collapsing onto itself for proper measurements. The right ulcer measured length of 4.5 cm x 3.5 cm width x 1.6 cm depth and with undermining from 7:00 to 4:00 o'clock at 1.7cm being the deepest, with no tunneling. RN-A removed her soiled gloves, and then used clean gloves and sprayed wound cleanser into each of the wound, and used skin prep on the edges of the wound. She removed her soiled gloves, and then proceed to pack the left ischial tuberosity, and used her left gloved hand to hold the calcium alginate packing dressing which is used to speed ulcer healing. RN-A used her right gloved pointer finger to pack

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F 441	Continued From page 22 the calcium alginate into the wound, touch the inside wall of the ulcer with her gloves, and continued to pack the area. Without changing her soiled gloves, RN-A then began to pack R2's right ischial tuberosity pressure ulcer with calcium alginate using the same soiled gloves. She used the left glove to hold the calcium alginate in her hand, and used her right soiled gloved hand and her pointer finger to pack the ulcer with the calcium alginate, touching the wall of right ischial tuberosity pressure ulcer while she packed the ulcer. After both the pressure ulcers were packed, without changing her soiled gloves, RN-A placed a foam dressing over both pressure ulcers and labeled and dated the dressing with RN-A initials. During interview on 10/22/14, at 10:05 a.m. RN-A stated she did not change her gloves or wash her hands between packing the multiple pressure ulcers. RN-A stated she should have washed her hands and changed her gloves between packing the right and left pressure ulcer, and for treatment of any resident with multiple wounds to prevent the chance of cross-contamination of wounds. The facility Hand Hygiene and handwashing procedure, June 2012 identified under the General Hand Hygiene Guidelines, Hand Hygiene Product Selection. Identifies can use alcohol-based hand rub for routinely cleaning your hands: "After having contact with body fluids, winds or broken skin..."	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 21, 2014. At the time of this survey, Good Samaritan Society Howard Lake was found 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 Occupancies. Good Samaritan Society Howard Lake is a one-story building with no basement. The original building was constructed in 1971, with building additions constructed in 1983 and 1994. All buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 32 at time of the survey.	K 000		

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

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.