



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
February 18, 2021

Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

RE: CCN: 245403
Cycle Start Date: February 3, 2021

Dear Administrator:

On February 3, 2021, a survey was completed at your facility by the Minnesota Department of Health 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On January 28, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 5, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 5, 2021, (42 CFR 488.417 (b)),. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 5, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/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 admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 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 \$11,160; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 3, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely

Good Samaritan Society - Battle Lake

February 18, 2021

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will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Battle Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 3, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC 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.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast

Rochester, Minnesota 55904-5506

Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 August 3, 2021 (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.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, 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 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after

receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. 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 Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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. Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 18, 2021

Administrator

Good Samaritan Society - Battle Lake

105 Glenhaven Drive

Battle Lake, MN 56515

Re: Event ID: HPT111

Dear Administrator:

The above facility survey was completed on February 3, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing".

Kamala Fiske-Downing

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

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

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesota
**This REVISED letter is to replace the letter dated February 18, 2021
To reflect the IJ cited as past noncompliance.**

Electronically delivered
March 19, 2021

Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

RE: CCN: 245403
Cycle Start Date: February 3, 2021

Dear Administrator:

On February 3, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the electronically attached CMS-2567

REMOVAL OF IMMEDIATE JEOPARDY

On January 28, 2021, the situation of immediate jeopardy to potential health and safety cited at F 689 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

Facility Name(}}

March 19, 2021

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SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Battle Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective February 3, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

To be acceptable, a provider's ePOC 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.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

Facility Name()

March 19, 2021

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, 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 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

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Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an

Facility Name()]

March 19, 2021

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explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Facility Name(]]

March 19, 2021

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Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 03/03/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/03/2021
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BATTLE LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(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	<p>INITIAL COMMENTS</p> <p>On 2/1/21 to 2/3/21, an abbreviated /extended survey was completed at your facility to conduct a complaint investigation. The facility was found not to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The survey resulted in an Immediate Jeopardy (IJ) past non-compliance at F689 when R1 had sustained a second degree burn on his left thigh from the application of a hot pack. The administrator and director of nursing (DON) were notified of the IJ on 2/2/21, at 4:34 p.m. Complaint H5403013C was substantiated at F689, at past non-compliance that started 1/25/21 and corrected on 1/28/21. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained.</p> <p>As a result of identifying substandard quality of care, an extended survey was conducted on 2/3/21.</p> <p>The following complaints were found to be substantiated with the associated tag:</p> <p>H5403013C. MN00069442 Deficiency issued at F689.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p>	F 000	Past noncompliance: no plan of correction required.		

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

TITLE

(X6) DATE

Electronically Signed

02/23/2021

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.

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

PRINTED: 03/03/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/03/2021
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BATTLE LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
(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	Continued From page 1	F 000			
F 689 SS=J	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate and sufficient supervision, implement facility policy to ensure heat treatments were applied in a safe manner to prevent injury and minimize the potential for serious injury, impairment or death with the use of hot packs for 1 of 1 residents (R1) who sustained a second degree burn to his left thigh with the placement of hot pack. These findings constituted an immediate jeopardy (IJ) situation for R1 who had the potential for serious injury, impairment or death. The immediate jeopardy was removed, and the deficient practice was corrected on 1/28/21, prior to the start of the survey and was therefore past noncompliance.</p> <p>The IJ began on 1/25/21, when trained medication aid (TMA)-A placed a hot pack prepared with hot water taken from the hot water</p>	F 689	Past noncompliance: no plan of correction required.	2/18/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245403	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/03/2021
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BATTLE LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515		
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F 689	<p>Continued From page 2</p> <p>coffee machine, placed under R1's left thigh without protection between his skin and the hot pack, and left R1 unattended. The administrator and director of nursing (DON) were notified of the IJ on 2/2/21 at 4:43 p.m. However, the facility had already implemented several actions which included modification of R1's care plan, education provided immediately to TMA-A and re-education regarding the facility policy, scope of practice, and expectations provided to TMA's and licensed nursing staff to ensure compliance was followed and to prevent reoccurrence.</p> <p>Findings include:</p> <p>R1's annual Minimum Data Set (MDS), dated 11/11/20, identified R1 had diagnoses which included paraplegia, peripheral vascular disease (PVD), and Diabetes Mellitus. The MDS identified R1 was cognitively intact, required total assistance for bed mobility, transfers, eating, personal hygiene, toileting, and locomotion.</p> <p>R1's Care Area Assessment (CAA) dated 11/11/20, identified R1's decreased mobility, loss of voluntary arm movement, total dependence for bed mobility, locomotion on unit, dressing, eating, toilet use, personal hygiene, bathing, and transfers. The CAA listed R1 had diagnoses including diabetes, paraplegia, neurological disorder, and PVD.</p> <p>R1's Careplan revised 1/29/21, listed R1 had no purposeful mobility R/T [related to] quadriplegia/spastic paraplegia E/B [evidenced by] need for assistance with mobility. The care plan identified R1 had 2nd degree burn to left posterior thigh and directed staff to encourage use of sheep skin between lift sling and leg with</p>	F 689			

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OMB NO. 0938-0391

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F 689	<p>Continued From page 3</p> <p>transfers to prevent additional shearing until burn is resolved.</p> <p>A review of R1's progress notes from 12/26/20 through 1/31/21, identified the following:</p> <p>-On 1/25/21, at 11:30 p.m. TMA-B provided cares to R1 and noted a warm pack under his left thigh. The warm pack was removed and had no towel or cloth between the plastic and R1's skin. TMA-B noted a red area approximately 5 inches by 7 inches rectangle area. R1 stated a TMA had applied it at 9:00 p.m. and he thought it was hot but did not say anything. At 3:00 a.m. the area was irregular shaped and raised in the center. At 5:30 a.m. the area had multiple blisters form on top. R1 had no complains of pain.</p> <p>- On 1/26/20, at 8:37 a.m. RN-B spoke with GNP (general nurse practitioner) regarding second degree burn to rear left thigh. GNP ordered silver sulfadazine [sic] cream to be applied BID (twice daily) until resolved. Cover with non-adherent dressing.</p> <p>-On 1/27/20, at 8:37 a.m. 2nd degree burn present to rear left thigh assessed with wound round this AM (morning). 2 large filled blisters have ruptured, revealing dermal wound bed. Minimal amount of serous exudate noted. At 10:41 p.m. blisters to area have drained and tx (treatment) done as ordered, some skin has sloughed off, one small area deeper then the rest, does not c/o (complain of) pain to the area, the other scabbed wounds cleansed and dressed as ordered.</p> <p>- On 1/29/20, at 10:06 a.m. communication/visit with physician, R1 has a large burn to upper</p>	F 689			

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F 689	<p>Continued From page 4</p> <p>posterior thigh (from hot pack) that is being treated with silver sulfanide [sic]. Does have increased redness around this area as well but this is more purplish in color and appears more consistent with scar tissue and is not warm touch. R1 did have 2 blisters open up to this area with dressing regimen also being utilized for this.</p> <p>-On 1/29/20, at 10:54 a.m. incident reviewed from 1/25/21. R1 was noted to have warm pack found underneath him on 1/25/21 on noc (night) shift. Noc shift noted this with cares around 11:30 p.m. and R1 had reported the hot pack was placed around 9:00 p.m. by a TMA on the evening shift but upon investigation it was determined that this was not passed on to the night shift and not re-checked. R1 noted to have several blisters develop to area during the noc and developed into 2nd degree burn. No barrier was used over the hot pack and no f/u (follow up). The hot pack was improperly prepared and placed by TMA.</p> <p>-On 1/29/20, at 5:47 p.m. communication visit with physician, bacitracin ointment 500 unit/GM (unit/grams) apply to left thigh burn topically two times a day for second degree burn after cleansing with NS (normal saline), then cover with dressing, and paper tape.</p> <p>A facility internal investigation report, dated 1/25/21, at 11:30 p.m. completed by registered nurse (RN)-A identified during R1's cares a warm pack was noted under R1's left thigh. Upon removal noted approximate 5 inches by 7 inches rectangle red areas on R1's skin. TMA placed a washcloth in a plastic bag and failed to place a towel or cloth between skin and plastic bag. R1 stated warm pack had been applied by TMA around 9:00 p.m. R1 stated it felt hot but did not</p>	F 689			

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F 689	<p>Continued From page 5</p> <p>say anything to staff. At 3:00 a.m. t/r [sic] checked area and had become irregular shaped and raised in the center. A treatment order was not identified to apply warm packs to that area only an order to monitor the boil like areas. Hot pack applied by TMA, not assessed after 20 minutes, and not removed. There was no cloth between the warm pack and the skin of the resident.</p> <p>During observation on 2/1/21, at 12:35 p.m. nursing assistant (NA)-A and TMA-C entered R1's room with a total lift machine to reposition him. A large piece of sheep skin was noted to be located between R1's left thigh area and the wheel chair. Both staff attached lift sling hooks to lift machine and raised R1 up into the air. R1 grimaced and stated "ouch my left thigh burn hurts."</p> <p>During observation on 2/1/21, at 2:15 p.m. registered nurse, wound nurse (RN)-B and NA-A transferred R1 from wheel chair to the bed using a total lift machine. RN-B and NA-A turned R1 onto his right side and lifted his pants over the left thigh area. An ace wrap was located around the lower left thigh and on the upper rear thigh two hydrophilic foam wound dressings (3 inches by 3 inches). The dressings were secured with primapore adhesive tape. RN-B stated the hot pack was to be placed on the boils but must have been placed further down on the thigh or possibly slid down. RN-B pulled down the ace wrap to expose the burn area located on the rear left thigh. R1 stated, "Oh, that's tender, be careful." RN-B indicated and verified the burn area was measured approximately 5 inches by 7 inches with two blisters that measured approximately 2 inches in diameter, and many other little blisters that covered the entire red burn area and drained</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>a minimal amount of clear liquid. RN-B also verified she measured the initial burn on 1/26/21 but had not measured it since then.</p> <p>During a telephone interview on 2/1/21, at 3:27 p.m. family member (FM)-A identified a hot cloth had been placed in a garbage bag and then under R1's left leg at the end of the shift. FM-A stated this was not ordered and it was not a procedure that should have been done. FM-A also indicated there was no communication in the chart or with other staff, and R1 received a large second degree burn to his left thigh with blisters.</p> <p>During observation on 2/2/21 at 8:25 a.m. Maintenance (M)-A used the facility thermometer and verified the water temperatures of all 3 hot water coffee machines in the facility and R1's bathroom sink water:</p> <ul style="list-style-type: none"> -Heritage dining room located on the 100 wing 172 degrees -Cottonwood dining room area located on the 200 wing 157 degrees -Fisherman dining room area located on the 300 wing 151 degrees -R1's bathroom sink 112.7 degrees <p>During interview on 2/1/21 at 1:22 pm TMA-C verified R1 needed total cares completed by staff and all transfers with a total lift machine. TMA-C bathed R1 today and identified a burn area on the back side of R1's left thigh. TMA-C also indicated a TMA applied a hot pack for the 2 boils located on the back side of R1's left thigh and during the shift change it got left on too long. The NA on the night shift found the hot pack. TMA-C identified the burn on R1's left thigh was pretty large, more than 6 inches long and wide, the skin surrounding</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>it is very red, and drained a yellowish color fluid with blood in it. TMA-C also indicated she was unsure if TMA's are allowed to apply hot packs.</p> <p>During interview on 2/1/21, at 1:35 p.m. R1 stated one week ago on 1/25/21 TMA-A entered his room at 9:00 p.m. with a hot washcloth in a clear garbage bag. TMA-A stated to R1 "it's really really hot" and placed it under his left thigh. R1 indicated he could tell it was very hot but never thought it would cause a burn with blisters. R1 stated TMA-A left the room, went home and never came back to check on it. R1 indicated around 11:00 p.m. NA-B rolled R1 onto his right side to position him for sleep. R1 stated NA-B stated, "Oh what is this?" and pulled out the hot pack, at which time NA-B informed R1 the left rear thigh was really red and had blisters. R1 stated he had a high level pain tolerance and thought he could take the heat but never thought it would cause a burn with blisters. R1 indicted he could not change positions in bed and was dependent on staff to help him. R1 indicated he expected TMA-A to come back and check on him prior to leaving the building.</p> <p>During interview on 2/1/21, at 4:38 p.m. TMA-A stated she worked 1/25/21 on the evening shift. TMA-A indicated she used a few drops of hot water taken from the hot water coffee machine and saturated the middle of a wash cloth. Once the water spread outwards on the cloth, she placed the wash cloth into a clear trash bag. TMA-A verified she forgot to put a towel barrier between the hot pack and R1's skin. R1 laid in bed and the hot pack was placed by TMA-A under his left thigh. TMA-A said she'd asked R1 if he felt ok or if it was too hot prior to leaving the room. TMA-A exited R1's room, did not return,</p>	F 689			

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F 689	<p>Continued From page 8</p> <p>informed TMA-D the hot packed had been placed, and went home. TMA-A indicated the DON called her on 1/27/21, and informed her it should have been a nurse that placed the hot pack, there was not an order for this treatment, and provided education regarding the facility policy on heat applications, and the TMA's scope of practice.</p> <p>During interview on 2/2/21, at 8:28 a.m. NA-B indicated she worked the night shift on 1/25/21. NA-B said at 10:30 p.m., R1 placed his light on and NA-B got him ready for bed. NA-B said when she turned R1, she noticed a hot pack under his left leg, and asked him what it was. NA-B removed the hot pack and saw a pretty large red mark that looked like a burn. NA-B notified RN-A. RN-A measured a bright stop sign red area it was 7 inches by 5 inches. NA-B and RN-A repositioned R1 him off of the left leg. At 3:00 a.m. NA-B repositioned R1 and noted the burn area on the left leg had started to blister. NA-B indicated there were a mixture of large and small blisters. NA-B stated she moved R1's left leg he grimaced, and said he could feel the burn. A cool tap water cloth placed in a bag was placed on R1's left leg by RN-A and removed 20 minutes later. NA-B indicated the burn area looked the same at that time and no open areas were noted.</p> <p>During interview on 2/2/21, at 11:12 a.m. TMA-D indicated she worked as a TMA on 1/25/21 evening shift. TMA-D identified TMA-A asked her if she could get a warm pack and had stated, "Yes go ahead." TMA-D identified TMA-A used too hot of water and placed it on R1's left leg. TMA-D indicated a hot pack should not have been applied to R1 by a TMA and R1 was not checked on after it was placed.</p>	F 689			

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F 689	Continued From page 9 During interview on 2/2/21, at 11:27 a.m. DON indicated she received a phone call on the morning of 1/26/21, from the night shift nurse to inform her at 9:00 p.m. a hot pack had been applied by the evening TMA to R1's left thigh, 11:00 p.m. the night shift TMA repositioned him, removed it and there was a red area. DON also indicated she was informed at the same time the burn looked worse by morning and had blisters. DON stated on the morning of 1/26/21 the wound nurse RN-B assessed it and confirmed it had all the qualities of being a second degree burn with blisters that remained intact. DON indicated it is uncertain if the hot pack was placed in the correct spot on the left thigh or if it slid down when the head of the bed was raised, however, R1 could not move himself. DON indicated a TMA should have not applied a hot pack, and indicated this was not in their scope of practice according to the facility policy. DON identified a heat application must be ordered by a physician and this treatment should be done by a nurse, restorative aides or a therapist provided with education to apply excessive hot or cold. DON stated there were many processes during this incident that were not correctly followed according to the facility policy and procedures. DON indicated there was a lack of communication and understanding for the TMA that applied the hot pack. DON indicated the facility did not have a policy specific to hot water packs and indicated the water from a resident's bathroom sink should be used instead of the hot water from the coffee machine. On 2/2/21, at 2:00 p.m. during a follow up interview with TMA-C she stated she met with DON the day after the recent TMA/licensed	F 689			

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F 689	<p>Continued From page 10</p> <p>nursing meeting, and received the necessary education regarding the facility policy, procedures, and scope of practice regarding the application of hot packs. TMA-C identified TMA's or NAs were not allowed to apply a warm pack per facility policy and if they have questions or concerns the staff nurse should be contacted.</p> <p>During interview on 2/2/21, at 2:45 p.m. wound nurse (RN)-B identified she assessed R1's left rear thigh burn on the morning of 1/26/21. RN-B indicated she had been informed a hot pack had been applied and left on by a TMA on the evening shift on 1/25/21. RN-B noted there were two intact large blisters and the entire red area was covered with small blisters. RN-B indicated the small blisters reabsorbed through the day on 1/26/21 and by the end of the day and the burn site started to weep a clear fluid.</p> <p>Review of facility policy titled Heat Applications date revised 11/24/20, identified the purpose of the policy was to apply heat treatments in a safe manner by responsible employees in the skilled care facility which included therapist, licensed nurse, rehabilitation nurse, or restorative nursing assistants with documented training. The policy addressed types of heat application such as K-pad (or aqua/thermia pad) and microwave heating packs (rice, grain or commercial packs). Further, the policy indicated a physician's order is required for heat application and time for treatment is usually 15 to 20 minutes.</p> <p>The IJ was issued at past non-compliance beginning on 1/25/21. The IJ was corrected on 1/28/20, prior to the start of the abbreviated survey. It was verified by observation, interview and document review the facility had</p>	F 689			

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F 689	Continued From page 11 implemented sufficient steps to remove the immediacy and correct the identified non-compliance. These steps included review of the the facility's policy, procedures, and orders needed for heat application, scope of practice, processes and expectations for TMA's and nurses who are supervising them, and communication of any changes noted to the nurse to ensure compliance was followed to prevent reoccurrence. The facility educated licensed nursing staff and TMA's on the policy and expectations for use of heat application for residents.	F 689			
F 840 SS=C	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g) (2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by:	F 840		2/23/21	

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F 840	<p>Continued From page 12</p> <p>Based on interview and document review, the facility failed to ensure an emergency dental agreement had been completed which had the potential to affect all 43 residents residing in the facility reviewed during the extended survey.</p> <p>Findings include:</p> <p>During the extended survey document review on 2/3/21, at 10:59 a.m. a copy of the facility dental agreement was requested. The facility was unable to provide a copy of an agreement. The Administrator confirmed the facility did not have a current dental agreement in place.</p>	F 840	<p>POC for F840 (No Dental Contract)</p> <p>1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice. -A dental agreement has been signed with Area Lakes Dental here in Battle Lake</p> <p>2) How the facility will identify other residents having the potential to be affected by the same deficient practice. -All residents have the potential to be affected by this practice, as noted in the CMS 2567</p> <p>3) What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. -The contract for dental services has been signed, and will be in place for a period of 1 year, and will auto-renew after that until either party gives a 30 day notice of their intent to cancel the contract.</p> <p>4) How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. -The contract will continue on until proper notice is given by either party. At that time, the facility will have 30 days to contract with another dental office. This allows the facility sufficient time to arrange for proper outside resources.</p>		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BATTLE LAKE	STREET ADDRESS, CITY, STATE, ZIP CODE 105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 2/1/21 through 2/3/21, surveyors of this Department's staff visited the above provider and the following correction orders are issued.</p> <p>The following complaints were found to be substantiated with no licensing order issued:</p>	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE
02/23/21

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2021
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2 000	<p>Continued From page 1</p> <p>H5403013C. MN00069442.</p> <p>The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE</p>	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00146	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2021
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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES	2 000		