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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 62HF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00021

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245600**
2.STATE VENDOR OR MEDICAID NO.
(L2) **336240000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BLACKDUCK**
(L4) **172 SUMMIT AVENUE WEST**
(L5) **BLACKDUCK, MN** (L6) **56630**

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 **04/22/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **30** (L18)
13.Total Certified Beds **30** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	30			
(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 :
Amy Charais, HFE - NE II 05/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/26/2021 (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
04/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 3, 2021

Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, MN 56630-2140

RE: CCN: 245600
Cycle Start Date: April 22, 2021

Dear Administrator:

On April 22, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 22, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by October 22, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	**172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630**

(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
E 000	Initial Comments On 4/22/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/19/21 through 4/22/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5600012C (MN59172) H5600013C (MN61524) H5600014C (MN61698) H5600015C (MN64729) H5600016C (MN66344, MN66494) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/12/2021

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.

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 1 resident (R11) reviewed for pressure ulcers. Findings include: R11's significant change Minimum Data Set (MDS) dated 2/17/21, indicated he had intact cognition and required extensive assistance with bed mobility and toileting and total assistance with transfers. The MDS identifed R11 was at risk for developing pressure ulcers and had one Stage II (partial thickness loss of skin presenting as a shallow open ulcer with a red/pink wound	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Corrective action will be accomplished for those residents found to have been affected by the deficient practice: R11□s Care Plan was reviewed to ensure appropriate interventions were in place to ensure he/she receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual□s clinical condition demonstrates that they were unavoidable	5/24/21

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F 686	Continued From page 2 bed, without slough) pressure ulcer. R4 was receiving pressure ulcer treatment and had a pressure reliveing device in bed and in the chair. The MDS did not identifiy R11 was on a turning and repositioning schedule. R11's care plan dated 2/21/21, identified a history of Stage II pressure ulcer to the left buttock on 2/4/21, and a Stage II pressure ulcer on the right buttock on 2/16/21. The care plan directed staff to reposition R11 every two hours. During observation on 4/20/21, at 8:08 a.m. R11 was seated in a recliner chair in his room with his feet up. R11 remained seated in the recliner with no offloading or repositioning at 12:18 p.m. (4 hours and 10 minutes) On 4/20/21, at 11:59 a.m. R11 stated he had pain in his rear and the nursing assistant (NA) asked him if he wanted to go to the dining room for lunch. R11 stated, "I need to change position, my butt gets tired of being sat on." During interview on 4/20/21, at 12:03 p.m. NA-A stated generally residents were supposed to be repositioned every two hours unless otherwise care planned. NA-A stated she did not think R11 had a repositioning schedule and would ask him periodically if he was okay. Further, when R11 was in the recliner he was able to shift his hips. At 12:09 p.m. registered nurse (RN)-A stated R11 had more than one pressure ulcer on his buttocks in the past but they were now healed. RN-A stated R11's care plan indicated he should be repositioned every two hours while in bed and in the recliner.	F 686	and that if he/she has pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: The Director of Nursing or designee, will review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. This review will include assurance that appropriate repositioning schedules are care planned for residents identified as being at risk for pressure ulcers. This will be completed by 5/24/21. Measures put into place or systemic changes made to ensure that the deficient practice does not recur: The facilities Skin Assessment Pressure Ulcer Prevention and Documentation Requirements □ Rehab/Skilled Policy was reviewed on 5/10/21. This policy references repositioning as often as directed by the care plan. The facilities Care Plan □ Rehab/Skilled policy was reviewed on 5/10/21. NA-A was educated on 5/11/21 regarding	

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 686	Continued From page 3 At 2:36 p.m. NA-A stated R11 was able to raise and lower his head when he was in the recliner and could also shift around. NA-A stated R11 was not offloaded as directed by the care plan. During interview on 4/22/21, at 9:53 a.m. the director of nursing (DON) stated R11 had previously had pressure ulcers on his buttocks. The DON stated R11 should have been offloaded every two hours when he was in the recliner chair. A facility policy related to following the care plan was requested but not received.	F 686	R11□s care plan relating to repositioning. All nursing staff will be educated on the importance of following the care plan and the deficient practice identified relating to timely repositioning of R11 by 5/24/21. All nursing staff will be educated on the facilities Skin Assessment Pressure Ulcer Prevention and Documentation Requirements □ Rehab/Skilled Policy. All nursing staff will be educated on the facilities Care Plan □ Rehab/Skilled policy by 5/24/21 Monitor of performance to make sure that solutions are sustained: The director of nursing or designee will conduct repositioning audits on R11 as well as other residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The audits will be conducted three times weekly for four weeks and 4 times monthly for two months. The results will be reported to the QAPI committee for review and recommendations. The QAPI committee will determine if further auditing needs are necessary. Completion Date: 5/24/21	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 3, 2021

Administrator
Good Samaritan Society - Blackduck
172 Summit Avenue West
Blackduck, MN 56630-2140

Re: State Nursing Home Licensing Orders
Event ID: 62HF11

Dear Administrator:

The above facility was surveyed on April 19, 2021 through April 22, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00021	A. BUILDING: _____ B. WING _____	C 04/22/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/19/21 - 4/22/21, a licensing and complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

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GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were found to be UNSUBSTANTIATED: H5600012C (MN59172) H5600013C (MN61524) H5600014C (MN61698) H5600015C (MN64729) H5600016C (MN66344, MN66494) 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00021	A. BUILDING: _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BLACKDUCK	172 SUMMIT AVENUE WEST BLACKDUCK, MN 56630

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely repositioning for 1 of 1 resident (R11) reviewed	2 900	Corrected Completion Date: 5/24/21	5/24/21

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2 900	Continued From page 3 for pressure ulcers. Findings include: R11's significant change Minimum Data Set (MDS) dated 2/17/21, indicated he had intact cognition and required extensive assistance with bed mobility and toileting and total assistance with transfers. The MDS identifed R11 was at risk for developing pressure ulcers and had one Stage II (partial thickness loss of skin presenting as a shallow open ulcer with a red/pink wound bed, without slough) pressure ulcer. R4 was receiving pressure ulcer treatment and had a pressure reliveing device in bed and in the chair. The MDS did not identifiy R11 was on a turning and repositioning schedule. R11's care plan dated 2/21/21, identified a history of Stage II pressure ulcer to the left buttock on 2/4/21, and a Stage II pressure ulcer on the right buttock on 2/16/21. The care plan directed staff to reposition R11 every two hours. During observation on 4/20/21, at 8:08 a.m. R11 was seated in a recliner chair in his room with his feet up. R11 remained seated in the recliner with no offloading or repositioning at 12:18 p.m. (4 hours and 10 minutes) On 4/20/21, at 11:59 a.m. R11 stated he had pain in his rear and the nursing assistant (NA) asked him if he wanted to go to the dining room for lunch. R11 stated, "I need to change position, my butt gets tired of being sat on." During interview on 4/20/21, at 12:03 p.m. NA-A stated generally residents were supposed to be repositioned every two hours unless otherwise care planned. NA-A stated she did not think R11	2 900		

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2 900	Continued From page 4 had a repositioning schedule and would ask him periodically if he was okay. Further, when R11 was in the recliner he was able to shift his hips. At 12:09 p.m. registered nurse (RN)-A stated R11 had more than one pressure ulcer on his buttocks in the past but they were now healed. RN-A stated R11's care plan indicated he should be repositioned every two hours while in bed and in the recliner. At 2:36 p.m. NA-A stated R11 was able to raise and lower his head when he was in the recliner and could also shift around. NA-A stated R11 was not offloaded as directed by the care plan. During interview on 4/22/21, at 9:53 a.m. the director of nursing (DON) stated R11 had previously had pressure ulcers on his buttocks. The DON stated R11 should have been offloaded every two hours when he was in the recliner chair. A facility policy related to following the care plan was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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	245600	A. BUILDING **02 - ACTIVITIES ADDITION** B. WING _____	**04/20/2021**

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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. At the time of this survey, Good Samaritan Society Blackduck Building 02 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/12/2021

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.

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. This facility was inspected as two buildings. Good Samaritan Society Blackduck is a 1-story building built at three different times. The first and major portion of the building was built in 1970, is 1-story with a basement and was determined to be Type I(332) construction. In 1996 a dining room/ PT addition was constructed to the north of the original building. This addition is 1-story, with a basement and was determined to be type II (111) construction. In 2009 a connecting link and	K 000		

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K 000	Continued From page 2 activities addition, Bldg 2, type V (III) was constructed to the north of the dining room. It is separated with a 2-hour fire barrier, 1-story, no basement. The facility has a complete automatic fire sprinkler system with quick response heads, and has a fire alarm system which includes smoke detection throughout the corridor system and in all common areas and battery operated smoke detectors in all resident rooms. The facility has a capacity of 30 beds had a census of 22 at the time of the survey. The requirements of 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility did not maintain the heating, ventilation, and air conditioning in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, section 9.2,	K 521	K521 NFPA 101 HVAC It is the policy of the facility to perform fire and smoke damper maintenance and testing per NFPA standards and	5/12/21

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K 521	Continued From page 3 19.5.2.1., NFPA 90A "Standard for the Installation of Air-Conditioning and Ventilation Systems" 2012 edition, section 5.4.8.1., and NFPA 80 "Standard for Fire doors and Other Opening Protectives" 2010 edition, section 19.4.1.1. This deficient condition could effect 30 of 30 residents. Findings include: On 04/20/2021, at 11:50 a.m., during a review of all available fire and smoke damper maintenance and testing documentation for the last 4 years, and an interview with the Maintenance Supervisor it was revealed that at the time of the inspection the facility could not provide any documentation comfirming they had completed an inspection of the fire and smoke dampers in the last four years. This deficient condition was verified by the Maintenance Supervisor.	K 521	requirements. And accept this facilities credible allocation of compliance and correct the citation K521. Corrective action will include: The Maintenance Mechanic will contract with fire and smoke damper maintenance and testing per NFPA requirements and preventative maintenance schedule. Fire Damper maintenance and testing was completed on 5/6/21. Assurance of on-going compliance: The completion of fire and smoke damper maintenance and testing will be reported to the safety committee for review and recommendations. The maintenance mechanic is responsible for compliance with this requirement. The actual or proposed date for completion of the remedy. 5/12/21.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of	K 712		5/11/21

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K 712	Continued From page 4 established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, it was determined that the facility failed to conduct 2 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, sections 19.7.1.2 and 19.7.1.6, during the last 12 months. These deficient conditions could affect 30 of 30 residents. Findings include: On 04/20/2021, at 11:11 a.m., during the review of all available fire drill documentation and interview with the Maintenance Supervisor the following deficient conditions were found: 1. The facility failed to conduct a 1st shift (day) fire drill in the 3rd quarter within the last 12 month period. 2. The facility failed to conduct a 2nd shift (evening) fire drill in the 4th quarter within the last 12 month period. This deficient conditions were verified by the Maintenance Supervisor.	K 712	K712 NFPA 101 Fire Drills It is the policy of the facility to perform and assure Monthly/Quarterly Fire Drills conducted in accordance with NFPA standards and requirements. Accept this facilities credible allocation of compliance and correct the citation K712. Corrective action will include measures to prevent a recurrence: Day shift and evening shift fire drills were completed on 5/11/21 and 5/10/21 to bring existing drill schedule into compliance. Preventative maintenance program and instructions will be updated to ensure quarterly fire drills are scheduled, completed, and documented once per shift per quarter. Drills will also be conducted on different dates, times, and locations. Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct and assure fire drills are performed to meet this NFPA standards and requirements and as identified in our preventative maintenance program.	

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K 712	Continued From page 5	K 712	The results of these fire drills and corresponding documentation will be reported to the safety committee for review and recommendations. This committee will ensure that the requirement for quarterly fire drills on each shift is being met. Auditing by the safety committee will continue for three months. Further auditing needs will be assessed based on whether or not substantial compliance is determined to have been met. The maintenance mechanic is responsible for compliance with this requirement. The actual or proposed date for completion of the remedy. 5/11/21	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC)	K 761		5/10/21

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K 761	Continued From page 6 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility did not complete the annual fire door inspections in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 8.3.3.1, 19.7.6 and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition sections 5.2.1. This deficient condition could affect 30 of 30 residents. Findings include: On 04/20/2021, at 11:30 a.m., during a during the review of all available fire door test and inspection documentation and an interview with the Maintenance Supervisor, the facility could not provide current documentation verifying that the fire door inspection had been completed within 12 months of the last annual fire door inspection that was conducted in December of 2019. This deficient condition was verified by the Maintenance Supervisor.	K 761	K761 Maintenance Inspection and Testing Fire Doors It is the policy of the facility to perform Corridor fire door inspections per NFPA standards and requirements. And accept this facilities credible allocation of compliance and correct the citation K761. Corrective action will include: The facility preventative maintenance program will be updated to include annual fire door inspections as scheduled. Assurance of On-Going Compliance The Maintenance Mechanic will perform annual fire door inspections per NFPA requirements and preventative maintenance schedule. Annual fire door inspections was completed on 5/10/21. The completion of fire door inspections will be reported to the safety committee for review and recommendations. The Maintenance Mechanic is responsible for compliance with this requirement. The actual or proposed date for completion of the remedy.	

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K 761	Continued From page 7	K 761	5/10/21.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient condition could affect 30 of 30 residents. Findings include: On 04/20/2021, at 11:20 p.m. during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment, and Chapter	K 901	K901 Fundamentals □ Building Systems Categories It is the policy of the facility to complete and review annually the Life Safety Code Risk Assessment in accordance with NFPA standards and requirements. And accept this facilities credible allocation of compliance and correct the citation K901. The Administrator and/or Maintenance Mechanic will complete the LSC Risk Assessment by 5/13/21. The Risk Assessment will include patient care equipment, electrical equipment, and gas equipment. Assurance of on-going compliance: The Environmental Services Director and/or designee will ensure the LSC Risk	5/13/21

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K 901	Continued From page 8 11 - Gas Equipment. This deficient condition was verified by the Maintenance Supervisor.	K 901	Assessment is reviewed at least annually by the safety committee to meet this NFPA standards and requirements and as identified in our preventative maintenance program. The Maintenance Mechanic is responsible for compliance with this requirement. The actual or proposed date for completion of the remedy. 5/13/21	