DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 21, 2022

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

RE: CCN: 245600
Cycle Start Date: September 8, 2022

Dear Administrator:

On November 1, 2022, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
September 23, 2022

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

RE: CCN: 245600
Cycle Start Date: September 8, 2022

Dear Administrator:

On September 8, 2022, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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"and/or 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, Minnesota 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 December 8, 2022 (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 March 8, 2023 (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,

Kamala Fiske-Downing

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

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 09/08/2022

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 9/6/22 through 9/8/22, 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 9/6/22 through 9/8/22, 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 complaint was found to be unsubstantiated: H5600018C (MN74509). 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554	Resident Self-Admin Meds-Clinically Approp	F 554		10/28/22

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

Electronically Signed | 10/03/2022

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 09/08/2022

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
F 554 SS=D	Continued From page 1 CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the ability to self administer medication for 2 of 2 residents (R2, R5) identfied to self administer medication. Findings include: R2's quarterly Minimum Data Set (MDS) dated 6/1/22, identified R2 was cognitively impaired. On 9/7/22, at 3:03 p.m. R2 was in his room with no staff present and an albuterol inhaler was observed on the table next to R2's bed. R2 stated the inhaler was always in his room and he used it on his own a couple times every day. Further, the nurses knew it was there. R2's Resident Self-Administration of Medications assessment dated 9/7/22, identified R2 was unable to self-administer medications. During interview on 9/8/22, at 1:20 p.m. licensed practical nurse (LPN)-A stated a self-administration of medication assessment would be completed upon admission and as needed. The nurse would notify the MD, would receive an order, enter the order, and then staff would be notified of the changes. R2's assessment dated 9/7/22, identified R2 was unable to self-administer medications.	F 554	F554 Resident Self-Admin Meds-Clinically Approp. Corrective action will be accomplished for those residents found to have been affected by the deficient practice: A comprehensive assessment was completed on R2 and R5 to ensure the ability to self administer medication. R2 had a self administration UDA completed on 9-9-2022. The interdisciplinary team determined that the resident is safe to self administer his/her albuterol inhaler. Care plan has been updated for R2 to reflect residents ability to safely administer his/her albuterol inhaler. R5 had a self administration UDA completed on 9-9-2022. The interdisciplinary team determined that the resident is safe to self administer his/her nasal spray. Care plan has been updated for R5 to reflect residents ability to safely administer his/her nasal spray. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:	

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 09/08/2022

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
F 554	Continued From page 2 On 9/8/22, at 1:40 p.m. LPN-A stated there was an albuterol inhaler on the bedside table in R2's room with approximately 70 doses left. Prior to leaving the inhaler in R5's room there should have been an assessment completed identifying the specific medication and the resident's ability to safely self-administer the medication. During interview on 9/8/22, at 3:53 p.m. the director of nursing (DON) stated a self-administration of medication assessment should include whether or not the resident had the cognitive ability to understand what the medication was, why they were taking it, and the frequency of the medication. The interdisciplinary team (IDT) would discuss and determined if the resident was safely able to administer the medication independently, and the nurse would request an order from the MD. The DON stated there should be documentation, either through an assessment or a progress note, identifying the recommendations from the IDT discussion. The DON stated the medical record lacked documentation that R2 had been assessed to safely administer the inhaler independently. R5's annual MDS dated 6/15/22, identified R5 had severe cognitive impairment. During observation on 9/6/22, at 2:40 p.m. R5 was observed in her room with no staff present and there was a bottle of Deep Sea nasal spray on R5's bedside table. During interview on 9/07/22, at 3:14 p.m. R5 stated the nasal spray remained at her bedside and she used the it whenever her nose felt	F 554	All residents have been reviewed to identify self administration of any medications. Self administration assessments have been completed and care plans have been updated to reflect the medications that are self administered. Measures put into place or systemic changes made to ensure that the deficient practice does not recur: The facilities Residents Self-Administration of Medication – Rehab/Skilled Policy was reviewed. Medication administration training will be completed for all RN, LPN, TMA staff. Education will also include review of Residents Self-Administration of Medication – Rehab/Skilled Policy. Monitor of performance to make sure that solutions are sustained: The director of nursing or designee will conduct audits to ensure that those residents that self-administer medications have been comprehensively assessed as appropriate to do so. Audits will be completed weekly for three months on any resident due for their quarterly MDS assessment, a significant change assessment, or a new admission to determine if resident is self administering medications, and if so has a comprehensive assessment been completed to reflect their continued safety to do so. The results will be reported to the QAPI	

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 09/08/2022

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
F 554	Continued From page 3 stuffed up. R5's medical record lacked documentation that a self-administration of medication assessment was completed. During interview on 9/8/22, at 9:52 a.m. R5 stated she administered the nasal spray by herself that morning and without the assistance of staff. During interview on 9/8/22, at 9:53 a.m. trained medical assistant (TMA)-A stated R5 kept a bottle of Deep Sea nasal spray at her bedside. During interview on 9/8/22, at 1:30 p.m. LPN-A stated she was unable to find a self-administration of medication assessment in R5's electronic medical record. During observation on 9/08/22, at 1:48 p.m. LPN-A entered R5's room, picked up the bottle of nasal spray, and read aloud the label identifying the bottle of Deep Sea nasal spray belonged to R5. During interview on 9/08/22, at 3:53 p.m. the DON stated there should be documentation, either through an assessment or a progress note, identifying if the resident was safe to administer medications independently. The DON stated the medical record lacked documentation that R5 had been assessed to safely and independently administer the nasal spray. The facility's Resident Self-Administration of Medication policy reviewed/revised date 10/15/21, directed staff to complete a resident Self-Administration of Medications assessment, and other steps including to discuss with the	F 554	committee for review and recommendations. The QAPI committee will determine if further auditing needs are necessary. The Director of Nursing is responsible for compliance with this requirement. Completion Date: October 28, 2022.	

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 09/08/2022

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
F 554	Continued From page 4 interdisciplinary team for determination, obtain a physicians order, update the residents care plan and to review quarterly and as needed.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed honor known beverage	F 561	F561 Self Determination	10/28/22

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 09/08/2022

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
F 561	Continued From page 5 choices for 1 of 1 (R6) reviewed for choices. Findings include: R6's quarterly Minimum Data Set (MDS) dated 6/21/22, identified R6 had mild cognitive impairment. R6's average daily fluid intake was 500 milliliters (ml) per day. R6's Dehydration/Fluid Maintenance Care Area Assessment (CAA) dated 4/21/22, identified R6 had previously been hospitalized to receive intravenous (IV) fluid due to poor fluid intake. The CAA further identified R6's care plan would be updated due to R6's risk for dehydration with poor intake at times. During a phone interview on 9/6/22, at 2:28 p.m. family member(FM)-A stated R6 was "stubborn" and just would not drink fluids unless it was something she liked. FM-A stated he discussed this with the facility many times and actually brought R6's preferred beverages or bottle of concentrated liquid intended to add flavor to water for R6's use. R6's care plan dated 9/7/22, identified R6 had a potential for nutritional problem such as weight/loss gain and malnutrition risk. Staff were directed to: - provide diet as ordered - provide a house supplement due to history of weight loss and poor intake with meals at times. - weights as ordered and as needed. - provide R6 with a calm, quiet setting at meal times with adequate eating time. - R6 will be placed at a table, near staff, for meals so that staff can assist R6 with meals as appropriate. - monitor closely/report signs and symptoms of chewing/swallowing difficulties, coughing,	F 561	Corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility has reviewed R6's beverage choices and will update his/her care plan to reflect resident's preferences. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Beverage preferences will be reviewed for all residents. Care plans will be updated to reflect these preferences. Measures put into place or systemic changes made to ensure that the deficient practice does not recur: The facilities Residents at Risk for Dehydration, Fluid Maintenance – Food and Nutrition policy was reviewed. The facilities Care Plan- R/S, LTC, Therapy & Rehab was reviewed. All staff will be trained on the facilities Residents at Risk for Dehydration, Fluid Maintenance – Food and Nutrition policy. All staff will be educated on providing choice and ensuring preferences are provided. Nursing staff will be educated on the facilities Care Plan – R/S/ LTC, Therapy & Rehab Policy. Monitor of performance to make sure that solutions are sustained: The director of nursing or designee will audit to ensure resident beverage	

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 09/08/2022

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
F 561	Continued From page 6 choking. The care plan did not address R6's beverage preferences. R6's Food and Nutrition Data Collection V3 dated 6/23/20, identified R6 preferred cranberry juice, orange juice, chocolate milk and liked flavored water. R6's average daily fluid intake was 240-360 mL. During an observation on 9/7/22, at 3:13 p.m. trained medication aide (TMA)-A and nursing assistant (NA)-A assisted R6 out of bed and TMA-A then administered R6's afternoon medications. R6 took each medication with a small bite of chocolate pudding. NA-A then assisted R6 to the facility living room. However, R6 was not offered a drink after taking her medications. On 9/7/22, at 3:26 p.m. NA-A stated R6 took in a "normal" amount of fluids every day. Staff offered fluids to every resident each time they entered a resident room. NA-A then stated she did not offer R6 fluids this time because she had just received a drink with her medication. "Oh wait, she didn't did she?" NA-A then went to R6 and obtained a 4 oz can of tomato juice with a straw from R6's room. NA-A gave the can to R6 and encouraged her to take a drink. R6 finished drinking the beverage and NA-A disposed of the can in the trash. During an observation on 9/8/22, at 8:12 a.m. R6 was eating her breakfast in her room. Housekeeper(HSK)-A sat next to R6 on a rolling stool. R6 had eaten her entire breakfast meal and HSK-A removed the soiled dishes and placed a Styrofoam cup with ice water and a 6 oz bottle of	F 561	preferences are being provided and care planned accordingly. Audits will be completed weekly for three months on any resident due for their quarterly MDS assessment, a significant change assessment, or a new admission to ensure care plans are updated and beverage preferences are being provided. The Director of Nursing is responsible for compliance with this requirement. Completion Date: 10/28/2022	

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 09/08/2022

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
F 561	Continued From page 7 cranberry juice in front of R6. R6 pointed at the ice water and stated "I don't like that". HSK-A stated "oh yea, I forgot that." HSK-A then took the ice water into the bathroom, poured the water down the sink and threw away the cup. However, HSK-A did not offer any alternative beverages. During an observation on 9/8/22, 8:31 am. licensed practical nurse (LPN)-A administered R6's medications with a small amount of chocolate pudding. LPN-A did offer a drink between each bite of pudding, but R6 stated she was just too full. R6 then whispered to LPN-A who stated R6 wanted prune juice. - At 8:36 a.m. LPN-A left R6's room without getting R6 prune juice but did stop NA-B in the hallway. LPN-A explained R6 wanted to lie down and wanted prune juice. However, NA-A then started answering call lights. - At 9:39 a.m. R6 was assisted to lie down, but was not given prune juice as she requested. During an interview on 9/8/22, at 2:04 p.m. LPN-A stated R6 had beverages in her room because R6's family brought her favorite beverages in so R6 would always have them available. All staff knew R6 had special juices and beverage flavoring drops for water. LPN-A stated R6's care plan did not address R6's favorite beverages. Staff should have absolutely offered an alternative whenever R6 stated she did not like something. During an interview on 9/8/22, at 2:59 p.m. the director of nursing (DON) stated R6 did not have trouble swallowing fluids, but did not drink enough. Staff should always offer fluids to R6 especially during medication administration. Additionally, the care plan should reflect R6	F 561		

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 09/08/2022

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
F 561	Continued From page 8 beverage choices and direct staff to provide them. During an interview on 9/8/22, at 3:24 p.m. the administrator stated staff were expected to offer fluids to all residents and especially preferences, if able. A facility policy regarding resident hydration was requested, but not received. A facility policy regarding care planning was requested, but not received.	F 561		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess for an identified skin change for 1 of 1 resident (R7) that was reviewed for skin non-pressure. Findings include: R7's quarterly Minimum Data Set (MDS) dated 6/14/22, identified R7 had moderate cognition and required assistance of two staff for activities	F 684	F684 Quality of Care Corrective action will be accomplished for those residents found to have been affected by the deficient practice: A comprehensive assessment was completed on R7 to determine whether there were identified changes in skin. R7 was seen by her primary care provider on 8/9/2022. TMA from facility attended	10/28/22

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 09/08/2022

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
F 684	Continued From page 9 of daily living (ADL's) including transferring, dressing and toileting. Diagnoses included cerebrovascular accident (stroke - an interruption in the flow of blood to cells in the brain), hemiparesis (weakness or the inability to move one side of the body), diabetes and polyneuropathy (a malfunction of the nerves that typically results in numbness, tingling or pain of the affected area). R7 did not had any ulcers or wounds including diabetic foot ulcers, bruises, or pressure ulcers during the assessment period. R7's weekly Skin Observations- V3 identfied the following: - 7/3/22, Fifth toe next to nail darkened black-unstageable and non blanchable. The tool lacked any measurements or further follow up. - 7/10/22, left pinky ow blackened just at the end of the toe. The tool lacked any measurements or further follow up. - 7/13/22, small toenail is blackened due to striking it a week ago. The tool lacked any measurements or further follow up. - 7/17/22, the tool did not address the fifth digit on the left foot. - 7/24/22, left toe, smallest toe has blackened area at the end of the toe. The tool lacked any measurements or further follow up. - 7/31/22, left toe, left pinky toe blackened below nail. The tool lacked any measurements or further follow up. No further skin assessments identfying the left toe were provided. R7's care plan dated 9/8/22 directed staff to inspect feet and skin daily and report abnormalities to the nurse.	F 684	this appointment and reports that MD did look at resident's feet and stated that they were normal. This was not documented by MD. The physician has been notified about the black area on R7's toe. An appointment has been set up for 10/10/2022 with his/her primary care provider. Staff will accompany resident to appointment to ensure toe is evaluated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents skin assessments and documentation were reviewed. All residents have a comprehensive skin assessment done on admission and upon return from the hospital. Weekly skin checks are completed by the nurse on all residents. Measures put into place or systemic changes made to ensure that the deficient practice does not recur: The facilities Wound and Pressure Ulcer Management – Rehab/Skilled policy has been reviewed. The facilities Skin Assessment Pressure Ulcer Prevention and Documentation Requirements – Rehab/Skilled policy has been reviewed. Education will be provided to all nursing staff regarding identification and documentation of changes in skin condition.	

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 09/08/2022

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
F 684	Continued From page 10 During interview on 9/6/22, at 2:18 p.m. R7 stated there was a black dot on her right little toe, and had diagnosis of diabetes and was concerned about the spot. R7 stated the nurses looked at the area, and nothing had been done and a doctor had not looked at it. R7's progress notes identified a fax had been sent to the doctor on 7/5/22, regarding residents non-blanchable, blackened area on the toenail of the 5th digit. R7's medical record lacked evidence of a comprehensive assessment of the the black area on the right toe and or a physician assessment of the area. On 9/8/22, at 1:49 p.m. licensed practical nurse (LPN)-A stated she was aware of the black area on R7's toe, and had looked at it but had not completed documentation in the medical record including assessments or progress notes. Upon observation, LPN-A stated R7's toenail bed was black, was not warm to touch, the toenail was intact and had not been loose. LPN-A stated she was uncertain why the toenail bed was black. On 9/8/22, at 8:22 a.m. nursing assistant (NA)-C stated R7 had an area on her little toe that looked like it may have been a sore and it turned almost bruise-like or black and blue. Upon observation of the area, NA-C stated R7's right 5th toe was black under the toenail. R7 stated staff looked at the toe but they didn't do anything about it. During interview on 9/8/22, at 8:38 a.m. LPN-A stated R7 had a black spot on her 5th toe, uncertain of which foot. LPN-A stated staff were aware of the area, had offered for resident to see	F 684	Monitor of performance to make sure that solutions are sustained: The director of nursing or designee will conduct audits to ensure a comprehensive skin assessment is completed on new admissions and with hospital returns. Audits will be completed of weekly skin checks that are completed by the nurse on all residents. These audits will also ensure proper documentation is completed on any changes in skin condition. Audits will be completed on six residents weekly for six weeks. The results will be reported to the QAPI committee for review and recommendations. The QAPI committee will determine if further auditing needs are necessary. The Director of Nursing is responsible for compliance with this requirement. Completion Date: October 28, 2022.	

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 09/08/2022

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
F 684	Continued From page 11 podiatry but resident had declined. R7's medical record lacked documentation a doctor's visit had been offered or declined. During interview on 9/8/22, at 2:50 p.m. the clinic nurse stated she was unable to find documentation in R7's clinic electronic medical record R7's doctor was aware of the black area on R7's toe. During interview on 9/8/22, at 4:10 p.m. the director of nursing (DON) stated when the nursing staff noticed the change in R7's toe, the area should have been assessed. The assessment should have included documenting the details and measuring the area. The staff should have communicated with other staff and followed up according to the doctor's recommendations. The area on R7's toe was first noted in the progress notes of the medical record on 7/5/22, identifying that the doector was notified. R7's medical record lacked documentation that the area was assessed, measured, or monitored on, before or after 7/5/22,by the nursing staff or the doctor, and was unable to determine if the area had changed or stayed the same. Further, the DON stated she had not been aware of the black area on R7's toe until earlier in the day on 9/8/22. The facility policy regarding skin assessment was requested but not received. The facility policy regarding wound assessment was requested but received.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/07/2022. At the time of this survey, Good Samaritan Society-Blackduck 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/03/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email 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. 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 activities addition Type V (III) was constructed to the north of the dining room. It is separated with a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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
K 000	Continued From page 2 2-hour fire barrier, 1-story, and no basement. The facility has a complete automatic fire sprinkler system with quick response heads. The facility has a fire alarm system which includes smoke detection throughout the corridor system and in all common areas. All resident rooms have battery operated smoke detectors (new in 2018). This building will be surveyed as one Type V(111) building. Building 02 will be closed effective on 09/07/2022. The facility has a capacity of 30 beds and had a census of 24 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		10/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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
K 351	Continued From page 3 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 09/07/2022, between 9:00 am and 12:00 pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in the following locations: 1) Food storage room, located adjacent to the main kitchen, lower level 2) Outside Maintenance Office, lower level 3) Storage closet, main level - East Wing 4) End of hallway storage closet - East Wing 5) Clean Laundry room - West Wing An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 351	K351 Sprinkler System - Installation Corrective Action will include: On or before 10/3/2022 all storage materials were removed from storage racks within the 18 inch clearance area under sprinkler heads in the following locations: 1. Food storage room, located adjacent to the main kitchen, lower level. 2. Outside maintenance office, lower level. 3. Storage closet, main level – East Wing. 4. End of hallway storage closet – East Wing. 5. Clean Laundry room – West Wing. A complete building walkthrough was completed to ensure 18 inch clearance under sprinkler heads. Assurance of On-Going Compliance: The administrator or designee will conduct routine inspections to ensure 18 inch clearance under sprinkler heads. Facility plans to monitor future performance to ensure solutions are sustained. The results of these audits will be reported to the facilities safety committee for review and recommendations. This committee will ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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
K 351	Continued From page 4	K 351	requirement for 18 inches of clearance under sprinkler heads is being met. Auditing by the safety committee will continue for three months. Audits will continue until substantial compliance is determined to have been met. Identify who is responsible for corrective actions and monitoring of compliance. The administrator is responsible for compliance with this requirement. The actual or proposed date for completion of the remedy is 10/14/2022.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K 363		10/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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
K 363	Continued From page 5 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/07/2022 between 9:00 am and 12:00 am, it was revealed by observation that the resident room door 110 (East Wing) and door 215 (West Wing) did not latch. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 363	K363 Corridor - Doors Corrective action will include measures to prevent a recurrence: On 9/30/2022 resident room doors 110 (East Wing) and 215 (West Wing) were audited to ensure that they latched appropriately. On 9/30/2022 all corridor doors were audited to ensure that they latched appropriately. Assurance of On-Going Compliance: The Administrator or designee will conduct routine audits on corridor doors to ensure they latch appropriately and make corrections if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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
K 363	Continued From page 6	K 363	Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The results of these audits will be reported to the safety committee for review and recommendations. This committee will ensure that corridor doors are maintained according to guidelines. Auditing by the safety committee will continue for three months. Audits will continue until substantial compliance is determined to have been met. Identify who is responsible for corrective actions and monitoring of compliance. The Administrator is responsible for compliance with this requirement. The actual or proposed date for completion of the remedy. Completion Date: 10/14/2022.	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		10/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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
K 511	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 09/08/2022 at 10:15 AM, it was revealed by observation that the electrical panel located in the East Wing main corridor hallway. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 511	K511 Corrective action will include: The electrical panel located in the East Wing main corridor hallway was secured on 9/7/2022. All electrical panels were inspected on 9/8/2022 to ensure they were secured. Assurance of on-going compliance: The Administrator or designee will conduct routine audits on electrical panels to ensure they are secure and make corrections if needed. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The results of these audits will be reported to the safety committee for review and recommendations. This committee will ensure that electrical panels are secured according to guidelines. Auditing by the safety committee will continue for three months. Audits will continue until substantial compliance is determined to have been met. Identify who is responsible for corrective actions and monitoring of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245600	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

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
K 511	Continued From page 8	K 511	The Administrator is responsible for compliance with this requirement. The actual or proposed date for completion of the remedy. Completion Date: 10/14/2022.	