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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: F9V5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00755

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245549**
2.STATE VENDOR OR MEDICAID NO.
(L2) **477840500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE**
(L4) **745 BASINGER MEMORIAL DRIVE**
(L5) **MOUNTAIN LAKE, MN** (L6) **56159**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/18/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **55** (L18)
13.Total Certified Beds **55** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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 :
Holly Kranz, Unit Supervisor 01/22/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/22/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1991
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2019

Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

RE: Project Number S5549031

Dear Administrator:

On December 21, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on December 6, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 18, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 15, 2019. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 6, 2018, effective January 15, 2019 and therefore remedies outlined in our letter to you dated December 21, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245549

January 22, 2019

Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 15, 2019 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: F9V5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00755

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2.STATE VENDOR OR MEDICAID NO.
(L2) **477840500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE**
(L4) **745 BASINGER MEMORIAL DRIVE**
(L5) **MOUNTAIN LAKE, MN** (L6) **56159**

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 **12/06/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **55** (L18)
13.Total Certified Beds **55** (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
	55			
(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 :
Wendy Buckholz, HFE NE II 12/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/02/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
02/01/1991
(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

December 21, 2018

Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

RE: Project Number S5549031

Dear Administrator:

On December 6, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 15, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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 a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the 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:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742 Fax: (507) 344-2723

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 March 6, 2019 (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 June 6, 2019 (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:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
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
	245549	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/3/18 through 12/6/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/3/18 through 12/6/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		1/15/19

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

Electronically Signed | 12/28/2018

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
	245549	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 580	Continued From page 1 results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify medical doctor (MD) regarding a wound for 1 of 1 resident (R15) who was reviewed for a non-pressure related skin condition. Findings include: R15's face sheet indicated current diagnoses of type 2 diabetes with chronic kidney disease, peripheral neuropathy, and ischemic heart disease. R15's annual Minimum Data Set (MDS), dated 9/20/18, indicated she requires extensive assist of one for transfers, bed mobility, dressing, toileting and personal hygiene. R15's care plan, dated 4/25/14, indicated potential impairment to skin integrity related to bladder incontinence, nonambulatory, diabetes and edema. Interventions to monitor location, size and treatment of dermatitis &/or rash. Report abnormalities, failure to heal, s/s of infection, maceration, etc. to health care provider. The care plan was revised on 12/5/18 after surveyor made the facility aware of the open area on the top, outer aspect of the left foot. A Nursing order, initiated on 11/17/18 indicated to check outer left foot every two days for redness and chart condition of skin. Nursing progress notes reviewed regarding open	F 580	F580 □ NOTIFY OF CHANGES The wound on Resident #15□s foot was assessed and her physician was immediately notified on 12/5/18. All other resident□s medical records were reviewed for notification of physician re: wounds. RN□s and LPN□s were educated on 12/13/18 regarding the need to note all open areas and schedule for continued monitoring and notification of the physician of these areas. Audits of physician notification of any new wounds noted will be completed weekly by the DNS or her designee for two months and then monthly for the next 2 months to determine if the physician is being notified timely as needed. Any issues identified from these audits will be addressed as needed. All audit results will be reported at the monthly QAPI meeting and further action will be determined by the QAPI committee as needed. Completion Date: January 15, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3	F 580		

are on top of left foot indicated:

-11/16/18 resident reported having pain in her left foot, when looking at the foot, there is an indented are on the top of the foot (middle section) with minimal amount of edema note. The outer left foot is a darker pink color with dried skin noted. When the new diabetic shoe was put on her foot the inside strap did rub in exactly that area. Resident to wear gripper socks through the weekend.

-11/17/18 Scratch on side of left foot healing, measures 1 centimeter (cm) X 0.1 cm. Slightly red around area; no drainage noted.

-11/19/19 Improvement noted to side of left foot. Less swelling and color no longer pink. Resident reported she is not in pain at this time and continues to wear gripper socks.

-12/3/18 Area is pink in color and skin abrasion is healing. Resident dose not c/o any associated pain.

Skin observations reviewed for 11/20/18, 11/27/18 and 12/4/18 all indicated no skin conditions were observed. There was also no mention in the record of notifying the medical doctor.

During interview and observation in R15's room of outer aspect of left foot, on 12/05/18 at 12:27 p.m. with registered nurse (RN)-C. R15 was wearing compression stocking to both legs. R15 indicated that staff were putting ointment on her foot. RN-C stated "I didn't know we were doing a treatment on it." R15 stated there is a little cup in my bathroom with ointment in it and they are putting that on twice a day. RN-C went into the

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GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(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 580	Continued From page 4 bathroom and got a medicine cup with clear looking ointment and put on R15's open area on top of her left food. RN-C described the wound as an open area with no signs or symptoms of infection, slough in the center. The reddened area around the open area is 1.8 cm X 2 cm, and the open area is 1.1 cm X .3 cm. During interview on 12/05/18 at 2:11 p.m., with RN-D stated she just went and observed the area after being informed by RN-A. The Medical doctor (MD) was informed of the area today and had not been informed of the area when it opened or before the area was brought to their attention by the surveyor. She also stated "honestly, I didn't know it was open I thought it had healed." During interview on 12/5/18 at 2:57 p.m., with the director of nursing (DON) confirmed the DON's expectation for wound assessment was for it to be identified, measured, monitored and tracked. The MD should be notified and updated. The measurement of the wound should be completed by one nurse so the measurements are accurate and ensure the treatment is working. A policy on notification to the provider was requested and one was not provided.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		1/15/19

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F 584	Continued From page 5 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to clean and maintain a resident wheelchair for 1 of 1 resident (R8) reviewed with soiled personal equipment.	F 584	F584 CLEAN AND SAFE ENVIRONMENT The wheel chair of resident #8 was cleaned. All chairs were audited to see if any other chair needed to be cleaned.	

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F 584	Continued From page 6 Findings include: Review of R8's face sheet, dated 12/6/18, indicated a diagnosis of cerebral palsy. R8's current care plan indicated he had a self-care performance deficit related to lower extremity weakness and poor coordination related to cerebral palsy and required extensive assist of one person to complete activities of daily living. Review of document entitled, wheelchair check list, revealed R8's wheel chair was cleaned in November, and was scheduled to be cleaned monthly. During interview on 12/4/18, R8 was found sitting in his wheelchair. The wheelchair was observed to have dried on food debris on the wheels spokes, the leg rests and the arms of the wheelchair, including the cushion, and down along the sides of the cushion. During observation on 12/5/18, at 12:02 p.m. R8 was observed in the dining room eating. The dried on food debris was still present on the wheels and leg rest, now there is a small candy wrapper wedged in the leg rest of the wheelchair. During observation and interview on 12/6/18, at 1:57 p.m. there continued to be dried on food and dirt on the foot pedals of the wheelchair, the armature of the wheelchair, and the seat cushion. When interviewed at this time, R8 was not aware of the soiled wheelchair and stated they would like to have it kept clean. During interview with the registered nurse (RN)-C on 12/6/18, she confirmed the wheelchair was	F 584	Housekeeping staff were talked to on an individual basis to educate them on the need to make sure chairs were thoroughly cleaned on a continuing basis according to a set schedule. Resident #8's chair cleaning has been reviewed and the schedule adjusted accordingly. Nursing staff were also educated on 12/20/18 and also through memo and in the nursing assistant communication book, on the need to observe chairs throughout the day while giving cares, and clean up any food or other soil noted immediately. Random audits for wheel chair cleanliness will be completed weekly for two months and monthly for the next three months by the housekeeping supervisor or her designee. All audit results will be reported at the monthly QAPI meeting and further action will be determined by the QAPI committee as needed. Completion Date: January 15, 2018	

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F 584	Continued From page 7 soiled and needed additional cleaning. A facility policy regarding wheelchair cleaning was requested. On 12/6/18, at 2:15 p.m. the director of nursing stated that the facility does not have a policy for cleaning of wheelchairs.	F 584		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a level II preadmission screening and resident review (PASRR) for 2 of 2 residents (R1, R4) reviewed with a new mental illness diagnosis. Findings include:	F 644	F644 LEVEL 2 SCREENING Residents #1 and #4 were referred to the county for assessment of need for Level 2 screening immediately. Diagnoses for all other residents were reviewed and compared to initial PASRR screening forms. For all residents with appropriate diagnoses, that were not included in their	1/15/19

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F 644	Continued From page 8 Review of R4's Diagnosis Report printed 12/6/18, indicated the resident was admitted to the facility on 10/16/07, with a primary diagnosis of multiple sclerosis (MS). Further review of the Diagnosis Report indicated R4 was diagnosed with delusional disorder on 12/7/17, and major depressive disorder, recurrent, severe with psychotic symptoms on 9/24/18. R4's quarterly Minimum Data Set (MDS) dated 11/21/18, indicated the client received antipsychotic and antidepressant medication daily. Review of R4's current physician orders printed 12/6/18, included: Risperdal (an antipsychotic medication) 1.5 milligrams (mg) by mouth two times a day related to delusional disorder and Zoloft (an antidepressant medication) 200 mg by mouth one time a day related to major depressive disorder, recurrent, in partial remission. Review of R4's care plan last revised 10/18/18, included: The resident has impaired cognitive function or impaired thought processes R/T (related to) MS E/B (evidenced by) varying alertness and response levels, episodes of mild confusion, delusional thinking, limitations in judgement. Some delayed processing noted. Orders items or makes requests, often denying or declining them a few days later. When interviewed on 12/4/18, at 3:31 p.m. the director of nursing (DON) stated when R4 was first admitted did not have the diagnoses of Major Depression disorder with psychotic features nor delusional disorder. DON further stated these diagnoses developed as her multiple sclerosis progressed. DON reviewed R4's medical record	F 644	original PASRR, a DHS 3457 form (Part A) was completed and sent to the county and cc□d to Larraine Pierce at DHS to be referred for further evaluation. Case Managers, Social Worker and HIM were all trained on the need for monitoring and identifying new diagnosis that would trigger the need for contacting the county for a Level 2 screening. Lists of new diagnoses will be audited by the Director of Nursing or her designee monthly for the next 6 months to monitor that all new potentially qualifying diagnoses are referred if needed. All audit results will be reported at the monthly QAPI meeting and further action will be determined by the QAPI committee as needed. Completion date: 12/26/2018.	

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F 644	Continued From page 9	F 644		

and confirmed a level II PASARR was not completed for the resident and asked "Should there be?"

R1's undated face sheet indicated current diagnoses of dementia, anxiety disorder, delusional disorder, visual hallucinations, and unspecified psychosis.

R1's care area assessment (CAA) worksheet for mood state, dated 8/27/18, indicated a potential problem for mood related to (r/t) depression, anxiety, dementia with Lewy bodies, hallucinations, sensations of bugs crawling on her, and itchiness. Wears Rivastigmine patch to reduce the crawly sensations.

R1's care plan, dated 9/25/17, indicated a psychosocial well being problem r/t depression, anxiety, and sensual and visual hallucinations evidenced by distractibility, picking at face and skin, sensations of worms and bugs crawling. Interventions include: Provide assistance/encouragement, guide conversations to positive thoughts, and resident uses multiple tissues to dab at her face and skin r/t sensual hallucinations, supply additional boxes of tissues as needed.

Review of health history and physician admission orders dated 12/16/16 indicated diagnoses of anxiety disorder. No other mental illness diagnoses were listed.

Preadmission screening reviewed dated

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F 644	Continued From page 10 12/30/16, included anxiety disorder and no other mental illness diagnoses were listed. During interview on 12/06/18 at 10:52 a.m., with the manager at the Senior Linkage Line regarding the Preadmission Screening and Resident Review (PASARR) level II is completed when the resident admits to the facility or they flag for a significant change or newly diagnosed mental illness. The facility needs to contact the county for re-assessment. During interview on 12/06/18 at 11:39 a.m. with the director of nurse (DON). "I was not aware a PASARR level II needed to be completed if they have a new diagnosis of mental illness. We will start doing that right now." A review of to policy titled, PASARR revised on 9/2017 indicated if the resident is dianosed with a mental disorder while in the location, the social worker will contact the designated state agency for a Level II screening.	F 644		
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	F 684	F684 QUALITY OF CARE	1/15/19

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F 684	Continued From page 11 review, the facility failed to assess, monitor and treat a wound for 1 of 1 resident (R15) reviewed for non-pressure related skin conditions. Findings include: R15's face sheet indicated current diagnoses of type 2 diabetes with chronic kidney disease, peripheral neuropathy, and ischemic heart disease. R15's annual Minimum Data Set (MDS), dated 9/20/18, indicated she requires extensive assist of one for transfers, bed mobility, dressing, toileting and personal hygiene. Also, brief interview for mental status indicated a 15/15, which indicated no cognitive impairment. R15's care plan, dated 4/25/14, indicated potential impairment to skin integrity related to bladder incontinence, nonambulatory, diabetes and edema. Interventions to monitor location, size and treatment of dermatitis &/or rash. Report abnormalities, failure to heal, s/s of infection, maceration, etc. to health care provider. Care plan was revised on 12/5/18 after surveyor made the facility aware of the open area on the top, outer aspect of the left foot. Nursing order initiated on 11/17/18 to check outer left foot every two days for redness and chart condition of skin. Progress notes reviewed regarding open are on top of left foot: -11/16/18 resident reported having pain in her left foot, when looking at the foot, there is an indented are on the top of the foot (middle	F 684	The wound for Resident #15 was assessed, measured and recorded. A monitoring schedule was established and wound assessments were done. RN's and LPN's were educated on 12/13/2018 on the need to monitor and assess wounds. Case Managers or their designee will be assigned to do wound evaluation on a consistent basis for accurate comparisons on all identified wounds according to facility procedure. RN's and LPN's were also educated on wound assessment and measurement by a representative of the wound clinic at the Windom Area Hospital on 12/27/2018. Other residents were evaluated for possible skin issues that had not been identified. The Director of Nursing or her designee will audit any newly identified open areas for proper assessment and monitoring for the next 3 months. All audit results will be reported at the monthly QAPI meeting and further action will be determined by the QAPI committee as needed. Completion date: January 15, 2018	

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F 684	Continued From page 12	F 684		

section) with minimal amount of edema note. The outer left foot is a darker pink color with dried skin noted. When the new diabetic shoe was put on her foot the inside strap did rub in exactly that area. Resident to wear gripper socks through the weekend.

-11/17/18 Scratch on side of left foot healing, measures 1 centimeter (cm) X 0.1 cm. Slightly red around area; no drainage noted.

-11/19/19 Improvement noted to side of left foot. Less swelling and color no longer pink. Resident reported she is not in pain at this time and continues to wear gripper socks.

-12/3/18 Area is pink in color and skin abrasion is healing. Resident dose not c/o any associated pain.

Skin observations reviewed for 11/20/18, 11/27/18 and 12/4/18 all indicated no skin conditions were observed.

During interview and observation in R15's room of outer aspect of left foot, on 12/05/18 at 12:27 p.m. with registered nurse (RN)-C. R15 was wearing compression stocking to both legs. R15 indicated that staff were putting ointment on her foot. RN-C stated "I didn't know we were doing a treatment on it." R15 stated there is a little cup in my bathroom with ointment in it and they are putting that on twice a day. RN-C went into the bathroom and got a medicine cup with clear looking ointment and put on R15's open area on top of her left food. RN-C described the wound as an open area with no signs or symptoms of infection, slough in the center. The reddened area around the open area is 1.8 centimeters (cm) X 2

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F 684	Continued From page 13 cm, and the open area is 1.1 cm X 0.3 cm. During interview on 12/05/18 at 2:11 p.m., with RN-D stated she just went and observed the area after being informed by RN-A. The Medical doctor (MD) was informed of the area today and had not been informed of the area when it opened or before the area was brought to their attention by the surveyor. She also stated "honestly, I didn't know it was open I thought it had healed." During interview on 12/5/18 at 2:57 p.m., with the director of nursing (DON) confirmed that staff need to be trained on skin assessments and stated "I think they are just looking at bony prominences." The DON's expectation for wound assessment was for them to be identified, measured, monitored and tracked. The MD should be notified and updated. The measurement of the wound should be completed by one nurse so the measurements are accurate and ensure the treatment is working. The policy titled, Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements revised on 4/2016 indicates: a skin inspection will be made daily by the nursing assistant for residents at risk for skin breakdown. The NA will report any abnormalities to the licensed nurse. The RN should record the type of wound and the degree of tissue damage on the wound RN assessment. Use the wound care treatment/prevention and dressing recommendations and fax communication to physician for wound care.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		1/15/19

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F 689	Continued From page 14 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop and implement interventions to provide adequate supervision for falls prevention for 1 of 1 residents (R27) who was reviewed for accidents. Findings include: R27's current Resident Face Sheet, printed 12/6/18 identified R27 was admitted to the facility 11/19/16 with diagnosis of Parkinson's disease (disease caused by a loss of nerve cells in the brain, which causes many different symptoms but most commonly slowness in movement and muscle stiffness), Meniere's disease (a disorder of the inner ear that can cause severe dizziness), weakness, and benign prostatic hyperplasia (condition where the prostate in men enlarges causing urinary problems including frequent urination). R27's annual Minimum Data Set (MDS) dated 10/11/18 identified R27 with moderately impaired cognition, a fall since previous quarterly assessment with no minor or major injury, required extensive assistance of one with transfers, locomotion on and off unit, dressing, toileting and bathing and had urinary urgency.	F 689	F689 FREE OF ACCIDENTS AND HAZARDS Resident #27's fall interventions were reviewed and the care plan was updated as needed. The process for assessing for fall interventions was reviewed and will be changed to include the full IDT team in the reviewing and implementing of new interventions on an individual basis following each fall. Other residents with recent falls were reviewed and care plan changes were made as necessary. Education was given to the RN's and LPN's on 12/13/18 on the need to be aware of resident at risks for falls and the need for a team effort in monitoring and preventing falls. Nursing assistants were educated on 12/20/18 on the need to be aware of what interventions are in place for each resident at risk for falls and to assist in implementing these interventions. Audits will be done on each fall for the next 3 months to determine if each one was evaluated in the IDT meetings and the care plan updated with new interventions. Completion Date: January 15, 2018	

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F 689	Continued From page 15	F 689		

The ADL Care Area Assessment (CAA) dated 10/17/18 identified R27 had restricted mobility and urinary urgency with need for assistance in toileting.

R27's care plan indicated R27 has an ADL self-care performance deficit related to Parkinson's disease with impaired balance issues, weakness, and episodes of dizziness. A care plan dated 1/31/17 identified R27 was at risk for falls with interventions including Dycem (non slip pad) on top of recliner seat to prevent sliding, candy dish to be within reach and ensure correct bed height by marking wall to top of mattress. On 10/16/18, an addition to the care plan included to review as indicated for significant changes in cognition, safety awareness and decision making capacity. A care plan intervention initiated 11/18/16, with last revision date of 10/12/18 indicated impaired cognitive function/dementia or impaired thought processes with limited recall and delayed thought processing. Level of alertness varies, as does ability to process and respond.

An event report dated 4/4/18, at 3:00 p.m. identified R27 was found on the floor in his bathroom with no apparent injury. He stated he had his call light on, but staff report the call light was not on. Intervention included checking call light for proper functioning and R27 demonstrate use of call light, which R27 was able to perform. No changes to plan of care.

An event report dated 4/5/18, at 6:15 a.m. identified R27 was found on the floor by his bed with no apparent injury. He did not have the call light on and was not able to state what he was attempting to do. Intervention was to complete

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scheduled medication review by the physician. No changes to plan of care.

An event report dated 4/21/18, at 8:45 p.m. indicated R27 was found on the floor in his room with no apparent injury. Call light was not on but was within reach. The intervention was to encourage use of the call light and to offer assist without waiting for resident to request it in light of his decreased cognition. No changes to plan of care.

An event report dated 5/14/18, at 8:10 p.m. identified R27 was found on the floor beside his recliner in his room with no apparent injury. R27 indicated he thought he put the call light on but it must not have gone on. Staff had him demonstrate use of call light which he was easily able to complete. Intervention included staff reminders to use the call light and to push more than once to be sure it goes on. No changes to plan of care.

An event report dated 8/9/18, at 2:50 a.m. identified R27 was found on the floor with no apparent injury. R27 was noted to be sleeping on rounds at 1:00 a.m. by staff. Intervention was to remind him not to transfer on his own and to use his call light. No changes to plan of care.

An event report dated 12/2/18, at 6:20 a.m. identified R27 was found lying on the floor in room at 6:20 a.m. with minimal injury. R27 demonstrated proper use of the call light. Intervention was to remind resident to wait for assist. No changes to plan of care.

During observation on 12/3/18, 10:01 a.m. R27 had shoes on and was sitting in wheelchair with

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foot pedals and call light in his lap. R27 had a 4 centimeter (cm) lump, dark purple in color on right side of forehead. The dark purple color extended down side of the eye to under the eye in an L shape approximately 8 cm in length and 3 cm width.

During interview on 12/3/18, at 10:01 a.m. R27 stated at 2:30 a.m. he fell sideways when he got up by himself to go to the bathroom. R27 stated he could not recall if he used his call light or not.

During observation on 12/6/18, 7:10 a.m. R27's area above the right eye had a dark purple lump measuring 3 cm, with yellow area extending outwards 6 cm's. The L shape area extending from lump down the side of face was 6 cm in length and 3 cm width. Under the eye was light purple 2 cm length by 4 cm width.

During interview on 12/6/18, 7:10 a.m. R27 stated to use the call light you just touch the button and it comes on. R27 further stated, "I fell down because it took over a half an hour before they answered my call light."

During interview on 12/6/18, 8:19 a.m. nursing assistant (NA)-A stated that staff remind R27 frequently to use his call light and it does help sometimes. She further stated there has not been any formal rounding or toileting program for R27. They just check on him when they have time.

During interview on 12/6/18, 8:34 a.m. director of nursing (DON) stated sometimes R27 is oriented and you can have conversations, but then the next time he wants to go out and milk the cows. "It varies so much for R27 so it is hard to try to

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come up with things to prevent falls for him."

During observation on 12/6/18, at 9:30 a.m. R27 placed the call light on. The call light was answered twenty three minutes later by NA-A at 09:53 a.m.

During interview 12/6/18, 9:46 a.m. registered nurse (RN)-C stated R27's falls are due to self-transferring and most of the time he is good at using his call light, but sometimes he just gets up and goes. During interview, RN-C stated "Oh, his light is on now" and continued to work at the computer.

During interview on 12/6/18, 10:43 a.m. the director of nurses (DON) was informed of twenty three minute call light for R27 and stated she was concerned. She further stated they have not done more frequent checks or a toileting program for R27.

During interview 12/6/18, 10:45 a.m. licensed practical nurse (LPN)-A stated for fall prevention they do frequent reminders to R27 to call for help.

During interview on 12/6/18, 12:58 p.m. RN-A stated the DON checks R27's call light log after falls to see if he put on his light. She further stated he is a hard one because of his Parkinson's disease. She further stated "we haven't done frequent checks on anyone in a long time here."

A review of the "Fall Prevention and Management" policy and procedure identifies the purpose is to identify risk factors and implement interventions before a fall occurs. It further states part of a proactive approach includes to care plan

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F 689	Continued From page 19 the appropriate interventions, including personalizing all "(SPECIFY)" areas.	F 689		
F 802 SS=D	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dietary staff had the appropriate competencies and oversight to complete proper cleaning of the kitchen, and with regard to food safety guidelines to ensure food was handled in a safe manner to prevent foodborne illness and was served in a palatable manner. This had the potential to affect all 47 residents residing in the facility who consumed food from the kitchen. Findings include:	F 802	F802 – SUFFICIENT DIETARY SUPPORT PERSONNEL To prevent further deficient practice a deep clean of the kitchen will be completed by January 4th 2019. The cleaning schedule has been reviewed and updated as necessary. Competencies of dietary staff in the areas of Hand washing, Date Marking, Sanitizing Food contact Surfaces, Cleaning Schedule, General Sanitation, Ware Washing, Food Temperatures will be completed by	1/15/19

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F 802	Continued From page 20 During the kitchen tour on 12/3/18, at 9:09 a.m. with the director of food and nutrition service (DFN) the following observations were made: 1. One three-shelf cart stacked ready with clean dishes for meal service had loose and dried on food debris and grease on all three shelves. 2. The top shelf of the stove was observed to be thick with dust, grime, and grease. 3. Dried food and grease were noted down the sides and surface of the stove and the steamer. 4. A double waffle maker stored on top of an open shelf was grossly soiled with dried-on brown and white food debris and grease. A stream of oil 6 inches long was observed on the plate of the waffle-maker that had dripped down from the waffle iron suspended above. 5. A mixer covered with a plastic bag which the DFN indicated "should be stored clean and ready for use", had dried on white and brown food debris on the guard, on the arms and a white, loose, powder-like substance. 6. The commercial grade manual can opener on the kitchen food service counter was noted to have an excess build-up of a black substance on the cutting blade and in front of and behind the cutting blade in the void space. The DFN stated the can opener was included on the cleaning schedule. 7. The microwave oven handle, had a grease-like substance covering the handle, and when opened had dried on food debris covering the bottom and sprayed on the sides and top of the unit. The cook revealed she had not used the microwave that morning. 8. The commercial-grade stove and steamer, had dried food and grease noted down the sides of the stove and surface, and dried-on thick grease on the burners and around each unit. The	F 802	January 4th. To identify other residents that have the potential to be affected, the facility's Abaqis software (a quality/survey readiness program) will be utilized to identify any potential concerns. A food committee has been established to include both residents and staff to meet regularly. Education was completed to dietary staff on 12-31-2018 to include Cleaning schedule and cleaning procedures, temperature recording and taking, hand washing and gloving, service of food or drink and competency completion. To ensure systemic changes are made, random audits will be completed on cleaning schedules and procedures, temp records, dating of food, hand washing and glove use by the dietary manager or designee one time weekly for 2 months then monthly times 2 months. To monitor corrective action and the deficient practice is being corrected all audit results will be reported at the monthly QAPI meeting and further action will be determined by the QAPI committee as needed. Completion date: 1-15-2019	

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handles of the door, and to the steamer were grimy on the surface and had thick grease, dust and were soiled with black and brown food debris.
9. Sheet pans stored ready for use on a wire shelf in the kitchen were not clean, when separated for observation seven pans had dried on and loose food debris on the surface and edges.
10. Plastic storage containers were cleaned and stacked ready for use, on 8 cup container exhibited a melted rough surface on the inside, the DFN removed the container and stated, "This needs to be thrown out."
11. Under the 3 section sink in the back of the kitchen a blue drain plunger was observed laying on its side on the floor. The DFN picked up the drain plunger and put it into an ice cream bucket, then stated "I don't know why it was left there, it is supposed to be in here."
12. A large container 2/3 full of a white flour like substance, did not identify the contents or the date the substance was opened.
13. A large container 1/2 full of a white granular sugar like substance, did not identify the contents or the date the substance was opened. The DFN stated, "The label must have fell off."
14. Observation of the refrigerator in the kitchen service area in the main dining room, had 2 dinner salads uncovered and undated, 2 dishes of coleslaw, and the DFN immediately disposed of them and stated, "These should have dates on them." The refrigerator also contained seven cartons of supplement, and one container of half and half that were open and undated. Stored at the back of the refrigerator were 4 trays of packaged pureed food that were thawed and dated, however, were expired. The DFN removed all of the containers and disposed of them in the garbage, and stated "They are outdated." The

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bottom of the refrigerator contained (2) half-gallon containers of juice with no identifying label, or date to identify when it was prepared. The inside of the refrigerator door and bottom surface had a dried-on thick milk, or cream, appearing substance covering an area of the door 2 feet long dried on the surface of the door, and the bottom of the refrigerator. The bottom of the refrigerator also had old dried on food debris.
16. The sink in the dining room food service area had a buildup of green and gray sediment around the faucet and bottom of the sink, and the base of the faucet has a black brown greasy substance, that when wiped with a paper towel and shown to the DFN, the DFN replied, "yuck".

Review of a facility document entitled Dietary Services Cleaning Schedule, dated 11/18 and 12/18 indicated the following uncompleted tasks:
1. Weekly cleaning of kitchen carts was not done in November or December.
2. Weekly cleaning of all cupboards was done once on November 3.
3. Daily cleaning of the stove was not done in November or December.
4. Weekly cleaning of the steamer and convection oven was not done in November or December.
5. The commercial grade can opener did not have a cleaning schedule.
6. Two times per day cleaning of the microwave was not completed in November or December.
7. Monthly schedule of cleaning refrigerator racks was not completed in November or December.

Further review of the monthly cleaning schedule indicated 372 opportunities for scheduled cleaning. Only 22 signatures indicating that the

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task for cleaning was completed were present in November out of 372 opportunities. As of 12/6/18, there were no signatures indicating that the tasks for cleaning were completed in December out of 77 opportunities.

During interview with cook (C)-A on 12/3/18, at 1:00 p.m. indicated that all appliances used during a meal preparation were to be cleaned after use and stored clean and ready to use again.

During observation on 12/3/18, at 11:03 a.m., the cook (C-A) washed hands and applied disposable gloves. After sorting through resident menu slips C-A started to serve individual plates of food for residents, and place them in the service window for staff to deliver. At 11:16 a.m., C-A opened the steamer door, grabbed oven mitts and removed 6 large and small containers off food and placed them in the steam table. C-A then grabbed the thermometer and alcohol wipes to check the temperature. With the same gloved hands, C-A continued to serve meals, grabbing menu slips from the serving window which were placed there by staff. C-A went to the grinder to put in a piece of ham, returning to the steam table and continued to serve resident food. C-A retrieved a tong utensil from the drawer, and continued with meal service. C-A then opened a cupboard door and grabbed a insulated plate, removed her gloves, applied new gloves, then started to serve more plates of food from the steam table. At 11:29 a.m., the serving handle for the ham dropped it down into the meat. C-A left the steam table and went to the grinder for the ground ham, removed her gloves and reapplied new gloves, and continued service from the steam table. At 11:38 a.m., C-A retrieved ketchup and dressing

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from the refrigerator and passed it through the serving window, then removed her gloves and reapplied new gloves. At 11:46 a.m. C-A continued to prep room trays and retrieved a pan of rice from the back of the steam table, setting the pan of rice directly into a pan containing fish. The ham entree was observed to be black across the top and sides and ¼ to ½ inch into the meat. One tray of ham sat atop another with the bottom of the first tray coming into direct contact with the food. The first 8 pieces appeared palatable, however, further inspection revealed the remainder of the ham was black on multiple surfaces. The FSS was present in the kitchen and out in the dining room, however, did not identify the food was burned and did not attempt to intervene.

During interview on 12/3/18, at 11:55 a.m., R40 stated the ham was burned and looked very overdone. R40 complained that the sweet potatoes were cold. R45 also complained that the ham was burned and dry.

During observation on 12/3/18 at 12:00 p.m., R2 was served a plate of ham and sweet potatoes. The ham on her plate was was black. When the plate was set in front of her, she asked the server "What is that?" R2's meat was cut up by a dietary staff member (unidentified), and the dietary staff were observed having a difficult time of cutting the meat up.

During observation on 12/3/18, at 12:05 p.m. R40 was observed the ham piece which was dry and black around the edges, and was observed to drop her head and shake her head back and forth. Another resident, R3, asked facility staff, "Why does the ham look that way?", the staff

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were unable to answer. During continuous observation of the dining room the DFN or dietary staff did not intervene or offer alternative choices to the residents who had been served food that was overcooked. At 12:22 the administrator was notified of the observation by the surveyor and went to the dining room.

During observation on 12/5/18, at 10:52 a.m. C-B was observed to check the food temperatures after loading the food into the steam table. There were 2 trays of pork chops in the table, and he only checked the temperature of the front tray. There were 2 trays of ground meat in the table, and he only checked the temperature of the front tray. He stated this was acceptable practice, and how he was taught. C-B was observed to set a container of mashed potatoes into the steam table and the temperature of the potatoes were never checked. At 12/5/18, at 11:41 a.m. C-B was serving plates from the steam table, removed his gloves and retrieved the hamburger from the pan on the stove using a spatula without checking the temperature of the hamburger patties prior to serving. At 11:45 am, upon surveyor the observation was stopped, and when interviewed the C-B confirmed he did not check the temperature of the hamburger, or the tomato soup that he retrieved from the microwave. The temperature of the hamburger did not calculate on the thermometer and was reheated to 170 degrees Fahrenheit.

During interview with DFN on 12/6/18, at 8:27 a.m., she indicated it was her expectation for the cook to provide oversight for a clean kitchen, and safe food service. The DFN further indicated that the orientation period for new cooks was four days.

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On 12/6/18, at 12:44 p.m., a phone message was left for the consulting dietitian.

During interview on 12/6/18, at 12:44 p.m., the administrator (ADM) reviewed the concerns identified during the survey, as well as the deficiencies issued by the Department for sanitation and infection control that had been issued involving the kitchen back to 2007. The history of citations for the kitchen for sanitation and infection control present eight of ten years. The ADM indicated she had met with the DFN supervisor multiple times regarding performance improvement, and there was no change. The ADM was shown the kitchen cleaning schedule, which identified that tasks were not being completed. The ADM indicated her expectation was a sanitary kitchen with safe food service directed by the DFN. The ADM indicated that during the meal service on 12/3/18 it was her expectation that the DFN would have offered the residents another choice and not served the black overcooked ham.

A facility policy entitled Resident Choice Dining, revised 9/17, indicated: Facility provides each resident with a nourishing, palatable, well balanced diet plan that includes food and drinks that meet his or her daily nutritional and special dietary needs, taking into consideration the preferences and allergies of the resident. 11. When a resident declines, a preplanned menu item, offer food and drink items that are similar in nutrition content.

A policy entitled Service of Food and Drinks, revised 7/18, indicated: Meals are served based on pre- planned posted menus and available

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options. Food is held at proper holding temperatures and or for appropriate lengths of time to ensure quality. Food and drinks are served attractive and palatable. Food and drinks are served at proper serving temperatures, taking into consideration the residents preferences.

A policy entitled Food Temperature Monitoring, revised 7/18 indicated: Food is cooked, reheated or cooled to ensure proper holding temperatures before each meal service. Food temperatures are taken and reordered before each meal service, periodically temperatures are taken at other times during or at the end of meal service to ensure temperatures are held with acceptable ranges. Food is served at proper serving temperatures.

A policy entitled Food Handling, revised 7/18 indicated: Food is handled in a manner that minimizes the risk of contamination, State and federal food service regulations pertaining to highly susceptible populations will be followed. Leftovers and snack items are handled to ensure food safety. Leftover food items will be covered, labeled, dated and stored immediately following meal service. Leftover cold foods are consumed or discarded within 3 days.

A policy entitled Date Marking, revised 7/18 indicated: Time/temperature control for safety foods items are date marked when received, when package is opened or when removed from the freezer for refrigeration. Dates are monitored to ensure food safety and quality for all foods in that location, including snacks stored outside the preparation kitchen.

Review of a policy entitled: Cleaning Schedule, revised 7/18 indicated: Purpose; to promote a

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 802	Continued From page 28 system that identifies cleaning tasks to be completed. To provide guidelines to employees for proper cleaning of kitchen equipment. 5. The DFN, is responsible for monitoring employees to ensure that cleaning duties are completed in a satisfactory and timely manner.	F 802		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a manner that was palatable to the residents. This deficient practice had the potential to affect all 47 residents residing in the facility who consumed food from the kitchen. Findings include: During observation on 12/3/18, at 11:03 a.m., the cook (C-A) the ham entree being served was observed to be black across the top and sides and ¼ to ½ inch into the meat. One tray of ham sat atop another with the bottom of the first tray coming into direct contact with the food. The first 8 pieces appeared palatable, however, further inspection revealed the remainder of the ham was black on multiple surfaces. The FSS was	F 804	F804 – PALATABLE/PREFER TEMP For residents #2, 3, 40, and 45 (awaiting confirmation of identification of residents #2 and #45 by the MN Department of Health) identified in F804 a suggestion or concern form will be completed and the practice addressed individually with each resident by the director of Food and Nutrition Services. To identify other residents who may be effected a food committee has been established to include residents and staff. Further, the facility's Abaqis software (a quality/survey readiness program) will be utilized to identify any potential food concerns of non-palatable food. To ensure systemic changes are made, staff were re-educated on 12-26-18 on	1/15/19

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F 804	Continued From page 29 present in the kitchen and out in the dining room, however, did not identify the food was burned and did not attempt to intervene. During interview on 12/3/18, at 11:55 a.m., R40 stated the ham was burned and looked very overdone. R40 complained that the sweet potatoes were cold. R45 also complained that the ham was burned and dry. During observation on 12/3/18 at 12:00 p.m., R2 was served a plate of ham and sweet potatoes. The ham on her plate was was black. When the plate was set in front of her, she asked the server "What is that?" R2's meat was cut up by a dietary staff member (unidentified), and the dietary staff were observed having a difficult time of cutting the meat up. During observation on 12/3/18, at 12:05 p.m. R40 was observed the ham piece which was dry and black around the edges, and was observed to drop her head and shake her head back and forth. Another resident, R3, asked facility staff, "Why does the ham look that way?", the staff were unable to answer. During continuous observation of the dining room the DFN or dietary staff did not intervene or offer alternative choices to the residents who had been served food that was overcooked. At 12:22 the administrator was notified of the observation by the surveyor and went to the dining room. On 12/6/18, at 12:44 p.m., a phone message was left for the consulting dietitian, no return call was received. During interview on 12/6/18, at 12:44 p.m., the administrator (ADM) reviewed the concerns	F 804	service of food and drink and food temperature monitoring. Competencies will be completed for dietary staff in these areas by January 4th. To ensure systemic changes are made, random audits will be completed on appearance of food and resident satisfaction to food one time weekly for 2 months, then monthly times 2 months. To monitor corrective action and the deficient practice is being corrected all audit results will be reported at the monthly QAPI meeting and further action will be determined by the QAPI committee as needed. Completion date: 1-15-2019	

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F 804	Continued From page 30	F 804		

identified during the survey, as well as the deficiencies issued by the Department for sanitation and infection control that had been issued involving the kitchen back to 2007. The history of citations for the kitchen for sanitation and infection control present eight of ten years. The ADM indicated she had met with the DFN supervisor multiple times regarding performance improvement, and there was no change. The ADM was shown the kitchen cleaning schedule, which identified that tasks were not being completed. The ADM indicated her expectation was a sanitary kitchen with safe food service directed by the DFN. The ADM indicated that during the meal service on 12/3/18 it was her expectation that the DFN would have offered the residents another choice and not served the black overcooked ham.

A facility policy entitled Resident Choice Dining, revised 9/17, indicated: Facility provides each resident with a nourishing, palatable, well balanced diet plan that includes food and drinks that meet his or her daily nutritional and special dietary needs, taking into consideration the preferences and allergies of the resident. 11. When a resident declines, a preplanned menu item, offer food and drink items that are similar in nutrition content.

A policy entitled Service of Food and Drinks, revised 7/18, indicated: Meals are served based on pre- planned posted menus and available options. Food is held at proper holding temperatures and or for appropriate lengths of time to ensure quality. Food and drinks are served attractive and palatable. Food and drinks are served at proper serving temperatures, taking into consideration the residents preferences.

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F 804	Continued From page 31 A policy entitled Food Temperature Monitoring, revised 7/18 indicated: Food is cooked, reheated or cooled to ensure proper holding temperatures before each meal service. Food temperatures are taken and reordered before each meal service, periodically temperatures are taken at other times during or at the end of meal service to ensure temperatures are held with acceptable ranges. Food is served at proper serving temperatures.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dietary staff stored, prepared and served food in a sanitary manner. This had the potential to affect all 47	F 812	F812 – FOOD PROCUREMENT, STORE/PREPARE/SERVE-SANITARY To prevent further deficient practice a deep clean of the Kitchen will be	1/15/19

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F 812	Continued From page 32 residents residing in the facility who consumed food from the kitchen. Findings include: During the kitchen tour on 12/3/18, at 9:09 a.m. with the director of food and nutrition service (DFN) the following observations were made: 1. One three-shelf cart stacked ready with clean dishes for meal service had loose and dried on food debris and grease on all three shelves. 2. The top shelf of the stove was observed to be thick with dust, grime, and grease. 3. Dried food and grease were noted down the sides and surface of the stove and the steamer. 4. A double waffle maker stored on top of an open shelf was grossly soiled with dried-on brown and white food debris and grease. A stream of oil 6 inches long was observed on the plate of the waffle-maker that had dripped down from the waffle iron suspended above. 5. A mixer covered with a plastic bag which the DFN indicated "should be stored clean and ready for use", had dried on white and brown food debris on the guard, on the arms and a white, loose, powder-like substance. 6. The commercial grade manual can opener on the kitchen food service counter was noted to have an excess build-up of a black substance on the cutting blade and in front of and behind the cutting blade in the void space. The DFN stated the can opener was included on the cleaning schedule. 7. The microwave oven handle, had a grease-like substance covering the handle, and when opened had dried on food debris covering the bottom and sprayed on the sides and top of the unit. The cook revealed she had not used the microwave that morning.	F 812	completed by January 4th 2019. The cleaning schedule has been reviewed and updated as necessary. Competencies of dietary staff in the areas of Hand washing, Date Marking, Sanitizing Food contact Surfaces, Cleaning Schedule, General Sanitation, Ware Washing, Food Temperatures' will be completed by January 4th. To identify other residents who have the potential to be affected, the facility's Abaqis software (a quality/survey readiness program) will be utilized to identify any potential concerns. Education was completed to dietary staff on 12-31-2018 to include Cleaning schedule and cleaning procedures, temperature recording and taking, hand washing and gloving, and service of food or drink. To ensure systemic changes are made random audits will be completed on cleaning schedules and procedures, temperature records, dating of food, hand washing and glove use by the dietary manager or designee one time weekly for 2 months then monthly times 2 months. To monitor corrective action and the deficient practice is being corrected, all audit results will be reported at the monthly QAPI meeting and further action will be determined by QAPI committee as needed. Completion date: 1-15-2019	

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F 812	Continued From page 33	F 812		

8. The commercial-grade stove and steamer, had dried food and grease noted down the sides of the stove and surface, and dried-on thick grease on the burners and around each unit. The handles of the door, and to the steamer were grimy on the surface and had thick grease, dust and were soiled with black and brown food debris.
9. Sheet pans stored ready for use on a wire shelf in the kitchen were not clean, when separated for observation seven pans had dried on and loose food debris on the surface and edges.
10. Plastic storage containers were cleaned and stacked ready for use, on 8 cup container exhibited a melted rough surface on the inside, the DFN removed the container and stated, "This needs to be thrown out."
11. Under the 3 section sink in the back of the kitchen a blue drain plunger was observed laying on its side on the floor. The DFN picked up the drain plunger and put it into an ice cream bucket, then stated "I don't know why it was left there, it is supposed to be in here."
12. A large container 2/3 full of a white flour like substance, did not identify the contents or the date the substance was opened.
13. A large container 1/2 full of a white granular sugar like substance, did not identify the contents or the date the substance was opened. The DFN stated, "The label must have fallen off."
14. Observation of the refrigerator in the kitchen service area in the main dining room, had 2 dinner salads uncovered and undated, 2 dishes of coleslaw, and the DFN immediately disposed of them and stated, "These should have dates on them." The refrigerator also contained seven cartons of supplement, and one container of half and half that were open and undated. Stored at the back of the refrigerator were 4 trays of

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packaged pureed food that were thawed and dated, however, were expired. The DFN removed all of the containers and disposed of them in the garbage, and stated "They are outdated." The bottom of the refrigerator contained (2) half-gallon containers of juice with no identifying label, or date to identify when it was prepared. The inside of the refrigerator door and bottom surface had a dried-on thick milk, or cream, appearing substance covering an area of the door 2 feet long dried on the surface of the door, and the bottom of the refrigerator. The bottom of the refrigerator also had old dried on food debris.
16. The sink in the dining room food service area had a buildup of green and gray sediment around the faucet and bottom of the sink, and the base of the faucet has a black brown greasy substance, that when wiped with a paper towel and shown to the DFN, the DFN replied, "yuck".

Review of a facility document entitled Dietary Services Cleaning Schedule, dated 11/18 and 12/18 indicated the following uncompleted tasks:
1. Weekly cleaning of kitchen carts was not done in November or December.
2. Weekly cleaning of all cupboards was done once on November 3.
3. Daily cleaning of the stove was not done in November or December.
4. Weekly cleaning of the steamer and convection oven was not done in November or December.
5. The commercial grade can opener did not have a cleaning schedule.
6. Two times per day cleaning of the microwave was not completed in November or December.
7. Monthly schedule of cleaning refrigerator racks was not completed in November or December.

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F 812	Continued From page 35	F 812		

Further review of the monthly cleaning schedule indicated 372 opportunities for scheduled cleaning. Only 22 signatures indicating that the task for cleaning was completed were present in November out of 372 opportunities. As of 12/6/18, there were no signatures indicating that the tasks for cleaning were completed in December out of 77 opportunities.

During interview with cook (C)-A on 12/3/18, at 1:00 p.m. indicated that all appliances used during a meal preparation were to be cleaned after use and stored clean and ready to use again.

During observation on 12/3/18, at 11:03 a.m., the cook (C-A) washed hands and applied disposable gloves. After sorting through resident menu slips C-A started to serve individual plates of food for residents, and place them in the service window for staff to deliver. At 11:16 a.m., C-A opened the steamer door, grabbed oven mitts and removed 6 large and small containers off food and placed them in the steam table. C-A then grabbed the thermometer and alcohol wipes to check the temperature. C-A continued to serve meals, grabbing menu slips from the serving window which were placed there by staff. C-A went to the grinder to put in a piece of ham, returning to the steam table and continued to serve resident food. C-A retrieved a tong utensil from the drawer, and continued with meal service. C-A then opened a cupboard door and grabbed a insulated plate, removed her gloves, applied new gloves, then started to serve more plates of food from the steam table. At 11:29 a.m., the serving handle for the ham dropped it down into the meat. C-A left the steam table and went to the grinder for the

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F 812	Continued From page 36	F 812		

ground ham, removed her gloves and reapplied new gloves, and continued service from the steam table. At 11:38 a.m., C-A retrieved ketchup and dressing from the refrigerator and passed it through the serving window, then removed her gloves and reapplied new gloves. At 11:46 a.m. C-A continued to prep room trays and retrieved a pan of rice from the back of the steam table, setting the pan of rice directly into a pan containing fish. The ham entree was observed to be black across the top and sides and ¼ to ½ inch into the meat. One tray of ham sat atop another with the bottom of the first tray coming into direct contact with the food. The first eight pieces appeared palatable, however, further inspection revealed the remainder of the ham was black on multiple surfaces. The FSS was present in the kitchen and out in the dining room, however, did not identify the food was burned and did not attempt to intervene.

During observation on 12/5/18, at 10:52 a.m. C-B was observed to check the food temperatures after loading the food into the steam table. There were two trays of pork chops in the table, and he only checked the temperature of the front tray. There were two trays of ground meat in the table, and he only checked the temperature of the front tray. He stated this was acceptable practice, and how he was taught. C-B was observed to set a container of mashed potatoes into the steam table and the temperature of the potatoes were never checked. At 12/5/18, at 11:41 a.m. C-B was serving plates from the steam table, removed his gloves and retrieved the hamburger from the pan on the stove using a spatula without checking the temperature of the hamburger patties prior to serving. At 11:45 am, upon surveyor the observation was stopped, and when

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interviewed the C-B confirmed he did not check the temperature of the hamburger, or the tomato soup that he retrieved from the microwave. The temperature of the hamburger did not calculate on the thermometer and was reheated to 170 degrees Fahrenheit.

During interview on 12/6/18, at 12:44 p.m., the administrator (ADM) reviewed the concerns identified during the survey, as well as the deficiencies issued by the Department for sanitation and infection control that had been issued involving the kitchen back to 2007. The history of citations for the kitchen for sanitation and infection control present eight of ten years. The ADM indicated she had met with the DFN supervisor multiple times regarding performance improvement, and there was no change. The ADM was shown the kitchen cleaning schedule, which identified that tasks were not being completed. The ADM indicated her expectation was a sanitary kitchen with safe food service directed by the DFN. The ADM indicated that during the meal service on 12/3/18 it was her expectation that the DFN would have offered the residents another choice and not served the black overcooked ham.

A policy entitled Service of Food and Drinks, revised 7/18, indicated: Meals are served based on pre-planned posted menus and available options. Food is held at proper holding temperatures and or for appropriate lengths of time to ensure quality. Food and drinks are served attractive and palatable. Food and drinks are served at proper serving temperatures, taking into consideration the residents' preferences.

A policy entitled Food Temperature Monitoring,

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F 812	Continued From page 38 revised 7/18 indicated: Food is cooked, reheated or cooled to ensure proper holding temperatures before each meal service. Food temperatures are taken and reordered before each meal service, periodically temperatures are taken at other times during or at the end of meal service to ensure temperatures are held with acceptable ranges. Food is served at proper serving temperatures. A policy entitled Food Handling, revised 7/18 indicated: Food is handled in a manner that minimizes the risk of contamination, State and federal food service regulations pertaining to highly susceptible populations will be followed. Leftovers and snack items are handled to ensure food safety. Leftover food items will be covered, labeled, dated and stored immediately following meal service. Leftover cold foods are consumed or discarded within 3 days. A policy entitled Date Marking, revised 7/18 indicated: Time/temperature control for safety foods items are date marked when received, when package is opened or when removed from the freezer for refrigeration. Dates are monitored to ensure food safety and quality for all foods in that location, including snacks stored outside the preparation kitchen. Review of a policy entitled: Cleaning Schedule, revised 7/18 indicated: Purpose; to promote a system that identifies cleaning tasks to be completed. To provide guidelines to employees for proper cleaning of kitchen equipment. 5. The DFN, is responsible for monitoring employees to ensure that cleaning duties are completed in a satisfactory and timely manner.	F 812		
F 865	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt	F 865		1/15/19

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F 865 SS=D	Continued From page 39 CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Refer to F802, the facility failed to ensure dietary staff had the appropriate competencies and oversight to complete proper cleaning of the kitchen, and with regard to food safety guidelines to ensure food was handled in a safe manner to prevent foodborne illness and was served in a palatable manner. This had the potential to affect all 47 residents residing in the facility who consumed food from the kitchen. Refer to F804, the facility failed to ensure food was served in a manner that was palatable to the residents. This deficient practice had the potential to affect all 47 residents residing in the facility who consumed food from the kitchen. Refer to F812, the facility failed to ensure dietary	F 865	F865 To address the deficient practice that affects all residents. The areas of concern mentioned in F802, F804 and F812 were brought to QAPI meeting on 12/27/2018 for review and actionable next steps for process improvement put in place. To identify other residents that have the potential to be affected by concerns mentioned in F802, F804 & F812 the facility's Abaqis software (a quality/survey readiness program) will be utilized to identify any potential concerns. To ensure systemic changes are made a QAPI program re-education will be completed by the Good Samaritan Society	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 865	Continued From page 40 staff stored, prepared and served food in a sanitary manner. This had the potential to affect all 47 residents residing in the facility who consumed food from the kitchen. During interview with dietary director (DFN) on 12/6/18, at 8:27 a.m., she indicated it was her expectation for the cook to provide oversight for a clean kitchen, and safe food service. The DFN further indicated that the orientation period for new cooks was four days. On 12/6/18, at 12:44 p.m., a phone message was left for the consulting dietitian, no return call was received. When interviewed on 12/6/18, at 1:49 p.m. the QAPI coordinatorregistered nurse (RN)-A confirmed during the quarterly QA meetings, issues with the kitchen were not discussed. RN-A stated at the monthly QA meetings (without the medical director or pharmacist present) there was discussion related to staffing and how to get things done timely with the kitchen and in the building. RN-A confirmed oversight in the kitchen would be the dietary manager's responsibility. RN-A further confirmed if oversight was lacking this would be a QA issue. RN-A confirmed this had not been an issue focused on in QA. During interview on 12/6/18, at 12:44 p.m., the administrator (ADM) reviewed the concerns identified during the survey, as well as the deficiencies issued by the Department for sanitation and infection control that had been issued involving the kitchen back to 2007. The history of citations for the kitchen for sanitation and infection control present eight of ten years. The ADM indicated she had met with the DFN	F 865	Quality Performance Improvement Consultant on 1-2-2019. Re-education will be in the areas of Basic QAPI Principles, Understanding Systems and Processes, QAPI and the Requirements of Participation, QAPI Policy and Procedures, QAPI workflow, QAPI Committee roles and responsibilities, data management. An audit will be conducted to ensure that all departments are utilizing the tools and processes laid out in the facility QAPI plan and of the QAPI committee to ensure proper oversight including identification of opportunities for improvement. The audits will be completed by the Administrator and GSS Quality Performance Improvement Consultant monthly x 12 months. All audit results will be reviewed by the QAPI committee for further recommendation. Correction date 1-15-19	

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F 865	Continued From page 41	F 865		

supervisor multiple times regarding performance improvement, and there was no change. The ADM was shown the kitchen cleaning schedule, which identified that tasks were not being completed. The ADM indicated her expectation was a sanitary kitchen with safe food service directed by the DFN. The ADM indicated that during the meal service on 12/3/18 it was her expectation that the DFN would have offered the residents another choice and not served the black, overcooked ham. Further, the ADM acknowledged being aware of repeated concerns with the condition of the condition and food quality and indicated they attended the quality assurance committee meetings.

Review of job description document for the Director of food and nutrition services, dated 8/17/16, indicated the job summary. This position is responsible to oversee department compliance with local, state, and federal regulations and to perform according to location standards and procedures.

A document titled: Quality assurance performance improvement plan(QAPI), dated November 2018 revealed: QAPI purpose statement: QAPI takes a structured and proactive approach that helps us to continually improve the way we care for and engage the people we serve, our co-workers and our business partners. QAPI helps us strive for excellence in all that we do. Ultimately, we focus on quality because it is the right thing to do.
Scope:
1. All departments and levels of care will implement QAPI and use QAPI methods and tools.
2. QAPI will address quality of life, quality of

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F 865	Continued From page 42 clinical care and services, safety and resident autonomy and choice. 3. QAPI will utilize evidence based bast practices, data, benchmarks and clinical guidelines to define and measure goals.	F 865		

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

F5549030

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	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2018**

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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, Building 01 of Good Samaritan Society Mountain Lake was found to be 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 Occupancies. Building 01 of Good Samaritan Society Mountain Lake was constructed as follows: The original building was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction; The 2000 building addition is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The 2013 link addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. There are no resident sleeping or treatment areas located in this addition. This addition is separated from an assisted living facility by a proper two-hour fire wall assembly. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.	K 000		

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

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

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K 000	Continued From page 1 The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 48 at time of the survey.	K 000		