



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 30, 2025

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: CCN: 245558
Cycle Start Date: December 11, 2024

Dear Administrator:

On January 27, 2025, we notified you a remedy was imposed. On January 27, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 27, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 11, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 27, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 11, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 27, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 27, 2025

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: CCN: 245558
Cycle Start Date: December 11, 2024

Dear Administrator:

On December 26, 2024, we informed you that we may impose enforcement remedies.

On January 23, 2025, the Minnesota Department of Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency(ies) not corrected is/are as follows:

K0521 - Hvac

REMEDIES

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

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 11, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 11, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 11, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 11, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Windom will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 11, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 11, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 26, 2024

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: CCN: 245558
Cycle Start Date: December 11, 2024

Dear Administrator:

On December 11, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor

Mankato District Office

Health Regulation Division

Minnesota Department of Health

12 Civic Center Plaza, Suite #2105

Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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 11, 2025 (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 11, 2025 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an

Good Samaritan Society - Windom

December 26, 2024

Page 4

explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 12/9/24-12/11/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 12/9/24-12/11/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55585211C (MN00104594) and H55582121C (MN00100115). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 550	Resident Rights/Exercise of Rights	F 550			1/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/03/2025

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

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 550 SS=D	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550			

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			
(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 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were provided care in a dignified and respectful manner for 1 of 3 residents (R13) who were observed during care interactions. Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 10/18/24, indicated R13 had moderately impaired cognition, had no rejection of care, was frequently incontinent of bladder, always continent of bowel, had a bowel toileting program, and was dependent for toilet transfers and toileting hygiene. R13's care plan dated 11/14/24, indicated a history of bowel incontinence related to loss of sensation, impaired mobility, needing staff assistance with transfers with a goal of 20 or less incontinent episodes of bowel movements through the next review date, constipation related to decreased mobility, frequent bladder incontinence related to stroke side effects with a goal of being continent of bladder during waking hours through the review date. R13's care plan further indicated a bowel toileting program with scheduled toileting times of 12:30 a.m., 6:45 a.m., 8:30 a.m., 1:00 p.m., 4:00 p.m., and 7:00 p.m. During observation on 12/11/24 at 7:29 a.m., nursing assistant (NA)-E answered R13's call light. R13 stated she needed to use the			F 550	Compliance Date and Responsible Party: Jan. 17, 2025 The Director of Nursing Services On Dec. 11, 2024, at 8:23am, R13 was assisted with toileting. NA-E was re-educated by the Director of Nursing Services on Dec. 11, 2024, with follow-up re-education occurring on Jan.7, 2025, regarding the need to help residents as requested. All residents are at risk for this deficient practice. As a result and to ensure systemic changes are sustained, all nursing department employees will be educated Jan. 13,15, & 17, 2025, by the Clinical Learning and Development Specialist regarding the policy to provide dignified and respectful care, as well as communication with residents related to fulfilling timely care requests. To ensure compliance, the QAPI Coordinator or designee will audit 4 residents requiring toileting assistance for 3 times per week on varying shifts, x12 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.		

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			
(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 550	Continued From page 3 commode. NA-E told R13 she had just gotten up and R13 would have to wait until after breakfast because NA-E was too busy getting people up. NA-E told R13 she should have asked to use the commode when she got up for the day. NA-E assisted R13 to the dining room in her wheelchair without assisting her to the commode per R13's request. During interview on 12/11/24 at 7:32 a.m., NA-E stated she told R13 she had to wait because she didn't have time to put her on the commode every 5 minutes. NA-E further stated R13 was jealous of NA-E helping other residents and turned her light on out of jealousy and attention. NA-E then stated R13 was always asking for something. During interview on 12/11/24 at 7:35 a.m., R13 stated she needed to use the commode but was told to wait until after breakfast. R13 further stated she was frequently told staff didn't have time in the morning and often could not use the commode when requested. R13 stated she had been embarrassed due to being incontinent in her brief due to having to wait to use the commode until after breakfast. During interview on 12/11/24 at 7:39 a.m., NA-D stated she would assist a resident if they requested to use the commode and if she was too busy, she would ask a different NA to help or would tell her charge nurse. NA-D further stated she would not tell a resident they could not use the commode when requested. During interview on 12/11/24 at 7:42 a.m., registered nurse (RN)-C stated he expected residents to be able to use the commode when requested and if the NA was too busy they could			F 550			

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			
(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 550	Continued From page 4 ask another NA for assistance or ask a nurse to help. RN-C further stated residents should use the commode when requested. During interview on 12/11/24 at 9:34 a.m., licensed practical nurse (LPN)-A stated she would expect residents to use the commode when requested and if the NA was busy they could tell the resident they would be with them as soon as possible or request help from another NA or the nurse. LPN-A further stated it was not acceptable to tell a resident they had to wait until after breakfast to use the commode. During interview on 12/11/24 at 11:36 a.m., director of nursing (DON) stated she would not expect a resident to be told they couldn't use the commode and would expect the request to be honored, and if the NA was overwhelmed they could tell the resident they would be with them as soon as possible, ask another NA for assistance, or inform their charge nurse of the need for assistance. During observation on 12/11/24 at 8:23 a.m., R13 was assisted back to her room from breakfast and her call light was illuminated. NA-D entered R13's room and assisted her to the commode. During interview on 12/11/24 at 8:52 a.m., NA-D stated R13 was incontinent of urine in her brief prior to using the commode and had a bowel movement in the commode. A review of NA-E's training record printed 12/11/24, indicated NA-E was trained in Sanford Health Nursing Assistant Training program, Changing the Culture to Person-Centered Care, Activities of Daily Living, and Communicating			F 550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 550	Continued From page 5	F 550			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to restore, maintain and prevent loss of range of motion (ROM) for 1 of 1 resident (R10) reviewed for limited ROM. Findings include: R10's facesheet printed 12/11/24, identified diagnoses of Parkinson's disease (brain disorder that causes unintended or uncontrollable movements), dementia, polyneuropathy (nerves that affects the skin, muscles and organs are damaged and can't sent signals back to the brain)	F 688			1/17/25
			Compliance Date and Responsible Party: Jan. 17, 2025 The Director of Nursing Services An occupational therapy order will be obtained for R10 by the Case Manager by Jan. 6, 2025, to re-assess the left hand and to assess the right hand for ROM treatments. The care plan will be updated by the Case Manager by Jan. 10, 2025, to reflect the new recommendations for R10. All residents receiving range of motion are at risk for this deficient practice. As a		

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			
(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 688	Continued From page 6 and peripheral vascular disease (veins/arteries in the arms, hands, legs and feet have restricted blood flow). R10's quarterly Minimum Data Set (MDS) assessment dated 10/25/24, identified R10 had severely impaired cognition, limited range of motion of both upper and lower extremities on both right and left sides, dependent on staff for eating, and all activities of daily living. R10's care plan dated 6/2/24, indicated R10 had a need for a functional maintenance program due to limited mobility in left fingers/palm. Goal included resident will remain free of complications related to immobility of left fingers and skin break down through the next review date. Interventions included complete passive range of motion (PROM) to left digits while wrapped in warm towels. Place palm splint on after PROM. Complete 10 repetitions, three times per week as needed and as tolerated. A physician order dated 5/15/24, included remove brace from left hand at bedtime for hand contracture. A occupation therapy (OT) Therapist Progress and Discharge Summary dated 5/31/24, by OT-B indicated caregiver is able to assist patient to complete PROM program for bilateral upper extremities (BUE) and wrist to reduce pain, avoid contractures, and maintain functional use of BUE. Patient has met goal of palm protector for left upper extremity to reduce pain, avoid contractures, and promote safe hand hygiene. Caregivers have been educated on strategies for safe use of palm protector and for PROM exercises to maintain current function of patients			F 688	result, by Jan.10, 2025, the care plans for all residents with limited range of motion will be reviewed by the DNS/Case Managers and updated as needed for restorative services with subsequent recommendations made to therapy as needed. To ensure systemic changes are sustained, the nursing department will be educated Jan. 13,15, & 17, 2025, by the Clinical Learning and Development Specialist on the policy for providing range of motion procedures, including who is responsible for completing ROM. To ensure compliance, the QAPI Coordinator or designee will audit 4 residents receiving ROM to assure it is being conducted, including application of a splint if required, weekly x12 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.		

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 688	Continued From page 7 BUE. A Therapy Documentation Note dated 5/31/24, by certified occupational therapy assistant (COTA)-C, included complete PROM on left digits while wrapped in warm towels. Place palm splint on patient after PROM one to three time per week as tolerated. During observation on 12/9/24 at 3:26 p.m., R10 was lying in her bed. R10's left hand was in a fist with no splint present. R10, upon request to move her left fingers, was able to move all but her middle digit approximately 1/2 an inch. R10's right hand's fingers were curled towards her palm with fingers touching her palm. R10's right wrist was also positioned prone at 30 degree angle. R10 was not able to move her fingers or her wrist on right side. During observation on 12/10/24 at 9:26 a.m., R10 was lying in her bed awake. No splint was present on her left hand. Left fingers were curled into palm of hand in a fist position. Right hand was curled into a fist and right wrist remained positioned downwards at 30 degree angle. On interview 12/10/24 at 9:52 a.m., nursing assistant (NA)-A indicated R10 is supposed to wear a splint but couldn't find it this morning. NA-A stated she doesn't do ROM on R10's hand and doesn't believe NA's do that and restorative aide is responsible for completing that task. On interview 12/10/24 at 11:10 a.m., nursing assistant (NA)-B, also identified as restorative aide, stated range of motion (ROM) is done every time the brace is put on because it takes the warm towels to loosen R10's fingers to put the	F 688			

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 688	Continued From page 8 brace on. NA-B indicated the brace should be put on every morning but she was unable to locate it this morning or yesterday. NA-B indicated when she is scheduled for restorative aide duties, she always stops in the morning and ensures ROM done and splint are applied, but NA-A stated she gets pulled from restorative duties frequently including the past two weeks. NA-B indicated the ROM and splint are only ordered for her left hand and not her right hand, but stated it looked like her right hand could use ROM and a splint also. On interview 12/10/24 at 1:46 p.m., licensed practical nurse (LPN)-B wasn't sure if R10 was supposed to be wearing a splint. LPN-B indicated she has noted R10's right hand is also contracted and she should probably get an order for therapy for evaluation. On 12/11/24 at 7:18 a.m., LPN-A stated ROM is completed on both R10's hands and she does have a splint for her left hand. During interview and observation on 12/11/24 at 7:38 a.m., LPN-B indicated the NA's can complete ROM but if the restorative aide is available she will complete it and apply R10's splint. Upon request LPN-B assessed R10's hands and indicated R10's right hand/fingers was not as contracted as they currently are the last time she evaluated them (was not able to identify when last evaluated) and added she will get an order for therapy to evaluate. R10 did not have a splint on her left hand and LPN-B stated sometimes the left hand splint doesn't get applied until later in the day. During observation on 12/11/24 at 8:01 a.m., R10	F 688			

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 688	Continued From page 9 is in the dining room with no splint on her left hand. Fingers continue curled into palms on both the right and left hands. During interview and observation on 12/11/24 at 8:19 a.m., occupational therapist (OT)-B, after reviewing notes from previous sessions April and May 2024, indicated R10 should be getting PROM to both hands and should wear a splint on her left hand throughout the day. OT-B stated R10 was not able to complete active range of motion, had zero strength on both hands and had facial grimacing with PROM of her left hand. Recommendations included PROM to both upper extremities. OT-B indicated written recommendations are given to the nursing staff upon discharge for recommendations to be completed for continued exercise program. At 8:36 a.m., OT-B completed evaluation of R10's hands. OT-B indicated no real change present on her left hand, however, R10 had no discomfort with PROM with her right hand during previous visit in April and May 2024, and now she does. OT-B added as soon as releasing fingers, they immediately returned to a curled position which could also indicate worsening of the motion in R10's right hand. OT-B indicated measurements of movement were never completed so it is difficult to state if her right hand/fingers/wrist are worse and can only base it on grimace on R10's face with passive movement. OT-B indicated with any change in either of R10's hands, a referral should be completed for OT evaluation. During observation on 12/11/24 at 12:40 p.m., R10 is in her room in her Broda chair (positioning chair) with no splint on her left hand. Facility Restorative Splinting policy dated 5/21/24,	F 688			

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 688	Continued From page 10 included: -Check electronic medical record (EMR) for resident specific restorative interventions -If care planned, provide ROM exercises to decrease muscle tone prior to application of splint Apply the splint as directed by physician and/or therapist instruction.	F 688			
F 690 SS=D	A policy on ROM was requested but not received. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690			1/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 690	Continued From page 11 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standards of care and practice for use of an indwelling catheter for 1 of 1 resident (R15) who used an indwelling catheter. Findings include: R15's facesheet, printed 12/11/24, included diagnoses of ulcerative proctitis (inflammatory bowel disease affecting only the rectum), insomnia, and hypothyroidism. There was no medical diagnosis indicating indication or rationale for Foley catheter. R15's quarterly Minimums Data Set (MDS) assessment dated 11/15/24, included moderately impaired cognition, requires partial to moderate assistance for toilet transfer, is continent of bowel and has an indwelling catheter. R15 does not have post void (urination) residuals greater than 250 cc. R15's Catheter Data Collection dated 11/15/24, indicated continued use of indwelling catheter. Reason for catheter was overactive bladder. Indications for use of catheter was checked as other with "specify other" left blank.	F 690	Compliance Date and Responsible Party: Jan. 17, 2025 The Director of Nursing Services R10: Discussion was held with the primary care physician on Jan 3, 2025. The physician reviewed R10's current GSS chart as well as his prior records and based on a Urology appointment in February 2023, an appropriate diagnosis was identified. Due to the PCP's schedule, the appropriate diagnosis for the use of the catheter for R15 will be obtained by the Case Manager by Jan. 7, 2025 and entered into the care record. Additionally, the PCP decided to ask for a follow-up Urology referral to assure the diagnosis continues to be appropriate going forward. We are awaiting more information regarding the upcoming appointment. All residents who have catheters are at risk for this deficient practice and as a result, will be reviewed by Jan. 10, 2025, by the DNS/Case Managers to assure appropriate diagnosis are identified. To ensure systemic changes are		

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			
(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 690	Continued From page 12 R15's plan of care dated 8/27/24, indicated R15 had an indwelling catheter related to overactive bladder with hygiene issues and causes anxiety. Interventions included monitor and document for pain/discomfort due to catheter, monitor for signs and symptoms of discomfort on urination and frequency, indwelling 16 french Foley catheter with 5 cc balloon, document output every shift, monitor/record/report to health care provider for signs of urinary tract infection, catheter care by nursing assistant with morning and evening cares, wear leg bag during the day and straight catheter drainage bag at night and report any unusual observations/conditions to the nurse. During observation and interview on 12/9/24 at 4:14 p.m., R15 was sitting in her room in her wheelchair. R15 stated she currently has a urine infection and she was told by her doctor her bladder doesn't work anymore and she gets frequent infections. R15 stated she has had problems for years with urinary tract infections and has seen multiple doctors for this in the past. During observation and interview on 12/10/24, at 9:15 a.m., R15 stated her doctor told her she needs to have a catheter because her bladder doesn't work anymore. R15 stated they put the catheter in about two months ago. During observation and interview on 12/11/24 at 7:10 a.m., nursing assistant (NA)-A indicated R15 has had a catheter a few months now but is unsure why she has one. During interview on 12/11/24 at 7:31 a.m., licensed practical nurse (LPN)-A indicated R15 has had a lot of urinary tract infections (UTI's), so R15's physician ordered a catheter to see if it			F 690	sustained, all licensed nurses will be educated Jan. 13,15, or 17, 2025, by the Clinical Learning and Development Specialist on the policy regarding the need for appropriate diagnosis for catheter use. To ensure compliance, the QAPI Coordinator or designee will audit any residents with a new catheter ordered for an appropriate diagnosis, x12 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.		

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			
(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 690	Continued From page 13 would help. LPN-A stated R15 has had one UTI since the catheter placement but feels this is less than previously. LPN-A stated the catheter is permanent and was not aware if post residual urine scans (amount of urine left in the bladder after urination completed by ultrasound scan of bladder) were ever performed or if she has seen a urologist. LPN-A contacted registered nurse (RN)-A, also identified as clinical leader, via phone. RN-A indicated R15 was given medication to try to empty R15's bladder but no tests were completed to see if bladder was emptying. RN-A stated a family member and R15 went to regular provider check up and asked if R15 could have a catheter to see if it would help with UTI's. RN-A indicated the provider listed reasons why she should have a catheter and placed an order for the Foley catheter. A provider note dated 7/15/24, included R15 has urinary incontinence 24/7. R15 indicated she can not make it to the bathroom and simply voids into pads and often has to wear multiple pads when she is out and about. R15 denies burning with urination, fever, chills, flank pain, suprapubic discomfort or change in urine itself. Discussed the possibility of an indwelling Foley. This would allow her to remain dry and not have to worry about being up and about. At the same time we discussed the fact that it is a foreign body and can increase the likelihood of infection. It may also cause bladder spasm, etc. It is not a perfect answer but one that has been considered in the past and one she would like to consider now. Suggested this begin no sooner than following an upcoming wedding, thus we will start the indwelling Foley catheter on 8/5/24. A provider order dated 7/15/24, indicated R15 to			F 690			

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 690	Continued From page 14 have an indwelling Foley placed to leg bag on 8/5/24 or thereafter. This is to be a permanent solution to her incontinence. During interview on 12/11/24 at 12:05 p.m., the director of nursing (DON) stated R15's diagnosis does not meet standard of care for a Foley catheter but added quality of life is important. The DON indicated R15 has not had a urology consult since she has been a resident at the facility. Facility Urinary Catheter policy dated 11/28/22, included: - An order and indication is required for an indwelling Foley insertion. Consider Foley catheter alternatives (i.e. external catheters and intermittent catheterization).	F 690			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880			1/17/25

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			
(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 880	Continued From page 15 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			F 880			

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

PRINTED: 01/08/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 880	Continued From page 16 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain a system to analyze monthly surveillance data for trends and patterns to reduce the spread of illness, infections, control transmission of infections and communicable diseases present in the facility. This had the potential to affect all 53 residents who resided in the facility. Findings include: Document titled Monthly Infection Summary August 2024, September 2024, November 2024, indicated resident name, start date, date symptoms resolved, type of infection, status, antimicrobial, infection source and surveillance of criteria met. No mapping or trending of the data was provided. On 12/11/24 at 10:32 a.m., during an interview registered nurse (RN)-B stated she was the infection nurse at the facility. RN-B stated she was responsible for overseeing the facility's infection control program and maintaining the facility's infection control surveillance log. RN-B stated the infections were tracked and documented on the computer tracking form, but no ongoing "formal" surveillance, monitoring of trends and/or breaks in infection practices had	F 880	Compliance Date and Responsible Party: Jan. 17, 2025 The Infection Control Preventionist All residents are at risk for this deficient practice. As a result, the Infection Control Preventionist will be educated by the GSS Lead Infection Preventionist by Jan. 17, 2025, regarding mapping and trending of the IC data to improve our surveillance program. We will also schedule a follow-up visit with the State of MN ICAR team to build on the education received. Tracking and analyzing will begin with the December 2024 data to be reported at the January 2025, QAPI meeting. To ensure systemic changes are sustained, all licensed nurses will be educated Jan. 13,15, & 17, 2025, by the Clinical Learning and Development Specialist regarding the Infection Control policy. To ensure compliance, the DNS, in conjunction with the GSS Lead Infection Preventionist, will audit the monthly infection control data for mapping and trending of infections, x4 months. Audit		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			
(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 880	Continued From page 17 occurred. When asked to review the infection data, RN-B used the tracking form on the computer and identified the infection control logs for the past few months. RN-B verified anything she had done regarding infection prevention was on done on an "informal" basis and confirmed the information was not tracked or analyzed. RN-B stated she was still in the process of learning all the components of infection preventionist role. RN-B stated infection data was reviewed at the end of the month and reviewed with the quality committee, On 12/11/24 at 11:08 a.m., the director of nursing (DON) verified the facility's infection surveillance was not comprehensive and residents were not tracked or compared for trending's or patterns The DON verified a monthly analysis of the illnesses and infections was important to rule out any trending or patterns, and interventions could be initiated to help prevent illness or infections including staff education and system process review. The DON verified the facility had not completed infection surveillance that included data collection, analysis of facility infections, tracking and trending of infections or illnesses within of residents or staff within the facility. Facility Infection Prevention and Control Program policy dated 12/2/24, indicated: To establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Surveillance The facility's surveillance system includes the			F 880	results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/11/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(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 880	Continued From page 18 data collection tool and then use of nationally recognized surveillance criteria to define infections. -resident infection surveillance is completed in the infection and antimicrobial tracking tool -resident infection surveillance is completed in safety zone Process surveillance and outcome surveillance are used as measures of the infection prevention and control program effectiveness. Data analysis that infection preventionist utilizes data gathered during surveillance to identify unusual or unexpected outcomes infection trends and patterns this data is reported the quality assurance and process improvement committee.	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/10/2024. At the time of this survey, Good Samaritan Society, Windom was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000			

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

Electronically Signed

TITLE

(X6) DATE

01/03/2025

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: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GOOD SAMARITAN SOCIETY - WINDOM was constructed at 5 different times. A one-story building with partial basement was constructed in 1959 and determined to be Type II (111). Additions were added in 1962, 1972, 1994, 2000 and all were determined to be Type II (111). Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From page 2 National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 63 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		1/10/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 353	Continued From page 3 by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1. These deficient findings could have an patterned impact on residents within the facility. Findings include: On 12/10/2024 between 9:00 AM and 12:00 PM, it was revealed by observation that there were lint covered sprinkler heads in the laundry area and dining room. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 353	Compliance Date and Responsible Party: Jan. 10,2025 Maintenance Mechanic On Dec.10, 2024, the lint was removed from the sprinkler heads in the laundry room by the Maintenance Mechanic. All residents and sprinkler heads are at risk for this deficient practice. As a result, all sprinkler heads were inspected and if not in compliance were dusted on Dec. 11, 2024, by the Maintenance Mechanics. To ensure systemic changes are sustained, the Maintenance Mechanics and Environmental Services Assistant will be educated on Jan. 10, 2025, by the Administrator regarding the policy for keeping the sprinkler heads free of dust. The schedule for cleaning the laundry sprinkler heads was increased to weekly. To ensure compliance, the QAPI Coordinator or designee will audit the laundry room sprinkler heads to assure they are dust free, weekly x4 weeks, monthly x 2 months, and quarterly x1 quarter. Audit results will be reviewed by the Safety Committee and the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with	K 355			1/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 355	Continued From page 4 NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.1.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/10/2024 between 09:00 AM and 12:00 PM, it was revealed by observation that multiple extinguishers in the resident corridors were not inspected monthly. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 355	Compliance Date and Responsible Party: Jan 10,2025 Maintenance Mechanic All fire extinguishers were inspected in December, 2024, by the Maintenance Mechanics. All residents and fire extinguishers are at risk for this deficient practice, as a result, the December 2024, inspections were verified by the Administrator on Dec. 11, 2024. To ensure systemic changes are sustained, on Jan 10, 2025, the Maintenance Mechanics will be re-educated by the Administrator on the policy of performing monthly checks of the fire extinguishers as required and directed in our TELS Preventative Maintenance system. To ensure compliance, the QAPI Coordinator or designee will audit that the fire extinguishers were checked monthly, x4 months. Audit results will be reviewed by the Safety Committee and the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		1/10/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 372	Continued From page 5 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 12/10/2024 between 9:00 AM and 12:00 PM, it was revealed by observation that there were multiple penetrations in the smoke barrier between the link and the administration area. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 372	Compliance Date and Responsible Party: Jan 10, 2025 Maintenance Mechanic The smoke barriers with penetrations, found during the survey, were corrected on Dec. 10, 2024, by the Maintenance Mechanics. All residents and atrium walls are at risk for this deficient practice. As a result, all smoke atrium walls were inspected on Dec. 10, 2024, by the Maintenance Mechanics and corrected if holes were found. To ensure systemic changes are sustained, on Jan. 10, 2025, the Maintenance Mechanics will be re-educated by the Administrator regarding the policy of smoke atrium walls of being penetration-free and the need to inspect them after a vendor has been here and potentially has penetrated the smoke atrium walls. Additionally, they will be educated on the newly added facility requirement of inspecting smoke atrium		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 372	Continued From page 6	K 372	walls twice per year for penetrations and correctly them if found. This task was added to our TELS Preventative Maintenance system on Dec. 31, 2024, by the GSS Environmental Health & Safety Consultant.		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.6.3. This deficient finding could have a widespread	K 521	To ensure compliance, the QAPI Coordinator or designee will audit the smoke atrium walls, if a vendor accesses the smoke atrium walls, to assure they are penetration-free, x4 months. Audit results will be reviewed by the Safety Committee and the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained. Compliance Date and Responsible Party: Jan. 10,2025 Maintenance Mechanic The smoke dampers were repaired on Dec. 16, 2024, by Automatic Building Controls, Inc. All equipment inspection reports were	1/10/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 521	Continued From page 7 impact on the residents within the facility. Findings include: On 12/10/2024 between 09:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility could not provide current documentation that the required repairs for the fire dampers had been completed at the time of the survey. Last inspection was completed on 06/05/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	reviewed by the Maintenance Mechanics by Jan. 3, 2025, for required repairs and no additional repairs were identified. All residents and inspection reports are at risk for this deficient practice. As a result, on Jan 10, 2025, the Maintenance Mechanics will be re-educated by the Administrator on the policy regarding the completion of repairs identified after a vendor visit for any equipment. Maintenance Mechanics will utilize calendar reminders to assure future repairs are done timely. To ensure compliance, the QAPI Coordinator or designee will audit any equipment inspection reports for the next 3 months to identify any needed repairs and that they are completed timely. Audit results will be reviewed by the Safety Committee and the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.		