

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0003 4738 3285

November 2, 2015

Mr. Marcus Parence, Administrator Good Samaritan Society - Winthrop 506 High Street Winthrop, MN 55396

Subject: Good Samaritan Society - Winthrop - IDR Provider # 245314 Project # S4302

Dear Mr. Parence:

This is in response to your letter of August 21st, 2015, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F428 at scope and severity of D issued pursuant to the recertification survey event 2CND11, completed on July 30, 2015.

The information presented with your letter, the CMS 2567 dated July 30, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F428-D 42 CFR § 483.60 (c) (10 (2) <u>Drug Regimen Review</u>: (1) the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist (2) the pharmacist must report any irregularities to the attending physican, and Director of Nursing, and these reports must be acted upon.

Summary of the facility's reason for IDR:

The facility practice for review of resident drug regimen were as follows: review done monthly by the consulting pharmacist and documented in the facility's electronc medical record system, in the progress note section of the individual record. A seperate report would be provided to the facility and placed in the hard copy portion of the medical record, if the consulting pharmacist made recommendations after review of the resident's drug regimen.

The facility provided copies of R30's progress notes from 7/16/14 to 7/26/15, which the DON stated was not provided at the time of the survey.

Good Samaritan Society - Winthrop November 2, 2015 Page 2

Summary of facts:

Review of the R30's progress notes provided by the facility, identified monthly medication reviews had been completed by the consulting pharmacist from 7/16/14 thru 7/26/15. R30's progress notes identified at the time of the monthly medication review, a report had been documented on 9/22/14, 11/24/15, 2/15, 3/20/15, 5/19/15. The facility indicated the staff had failed to direct the surveyor as to the location of the information in the medical record at the time of the survey.

This is not a valid deficiency at this tag and will be removed from Statement of Deficiencies (CMS-2567 form)

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Sail anderson

Gail Anderson, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 218-332-5140 Fax: 218-332-5196

cc: Office of Ombudsman for Long-Term Care Pam Kerssen, Assistant Program Manager Licensing and Certification File Gloria Derfus, Metro C Unit Supervisor

GS Winthrop IDR

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OATE SURVEY
		245314	B. WING)7/30/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	' - WINTHROP		506 HIGH STREET WINTHROP, MN 55396	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 000	INITIAL COMMEN	TS	F 000		
F 246 SS=D	as your allegation of Department's accelent enrolled in ePOC, at the bottom of the form. Your electro be used as verifical Upon receipt of an on-site revisit of yov validate that substaregulations has be your verification. 483.15(e)(1) REAS OF NEEDS/PREFINA A resident has the services in the faci accommodations of preferences, exception	of correction (POC) will serve of compliance upon the optance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an our facility may be conducted to antial compliance with the en attained in accordance with SONABLE ACCOMMODATION ERENCES right to reside and receive lity with reasonable of individual needs and ot when the hes an or s fety of her residents v. ruld ' a	- 246		9/7/15
	This REQUIREME by: Based on observa review, the facility i within reach for 1 c light was out of rea treatment. Findings include: On 7/28/15 at 9:55	NT is no. met as evidenced tion, interview and document failed to ensure a call light was of 1 resident (R46) whose call the during a specialized		F246 Resident #46 was given his call light at the time it was brought to staff attention that it was not within his reach. All residents are identified as having the potential to be affected by this deficient practice. All staff will be educated on the need to make sure residents in their rooms can reach their call lights by 8-27-15. For those not attending the meeting, make u	
		DER/SUPPLIER REPRESENTATIVE'S SIGN		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.

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		CON	IPLETED
		245314	B. WING _			07/	30/2015
NAME OF I	PROVIDER OR SUPPLIER	• •		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP			06 HIGH STREET /INTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 246	Continued From pa	ige 1	F 24	46			
	pumps on both legs hanging on R46's g should the resident staff. A licensed pra the room and the re pointed out to the L not within reach" ar armrest. LPN-A sta been within the res he could then reach R46's admission M indicated R46 had The corresponding analysis dated 6/14 assistance with act including bed mobi personal hygiene. T was at risk for falls sitting balance and transitions. R46's care plan dat had an ADL self-ca required cues for p plan also indicated related to weaknes and modify environ have caused or cor On 7/28/15, at 9:55 resident had arteria use call light for as On 7/28/15, at 10:5	s. The call light cord was grab bar and not within reach have needed assistance from actical nurse (LPN)-A entered esident's call light position was .PN. LPN-A stated, "No, it is nd moved it to the recliner ted the call light should have ident's reach, and R46 stated n and use the call light. inimum Data Set dated 6/9/15, moderately impaired cognition. Care Area Assessment (CAA) 4/15, revealed R46 required ivities of daily living (ADLs) lity, dressing, toileting and The CAA indicated resident related to difficulty mount aning impaired balance during ted 6/2/15 indic. If resident resident was accessful for falls s. Staff and directed to review mental haz inds that could htributed to falls.			education will be completed by 9-7 Call light audits will be completed a week x 4 weeks, then monthly x3 DNS or designee. The results of t audits will be presented to the Qua Committee to further recommend Date of completion is 9/07/15.	3x per by the hese ality	
	consultant director when resident was	of nursing (CDON) stated in his room, the call light within reach whether R46 was					

If continuation sheet Page 2 of 14

		AND HUMAN SERVICES			FORM	11/02/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION (E SURVEY PLETED
		245314	B. WING _		07/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 246	Continued From pa	ge 2	F 24	46		
F 254 SS=D	leaving the room, p reach of resident if call light cord acros reach it." 483.15(h)(3) CLEA GOOD CONDITION	ovide clean bed and bath	F 2	54		9/7/15
	by: Based on observat review the facility fa sanitary bed linens of 1 resident (R5) re living. Findings included: On 7/28/15, at 10:0 observations the fit large brown smear, On 7/29/15 at 7:20 wheeled to the dinin the meal, at 8:20 a. was transferred bac into the recliner cha fitted sheet on R5's large brown smear, On 7/29/15, at 9:22 (LPN)-B, during a s	NT is not met as evidenced tion, interview and documer ailed to ensure clean and were provided as needed for eviewed for activites c. faily 8 a.murin, R5's hor ted sheet with noted to have a by the rich, grached to be ng room in a wheelchair. After m., with staff assistance R5 ck to her room and assisted air. During this observation, the bed was still soiled with a up near the bed rail.		-254 The bed linens were changed immediately upon being notified that bed linens were soiled for Resident a All residents are identified as having potential to be affected by this deficit practice. Bed linens were checked a changed as appropriate on 8-20-15. All staff will be educated on the GSS policy and procedure for resident environment by 8-27-15. For those attending the meeting, make up edu will be completed by 9-7-15. Bed linen audits will be completed 33 week x 4 weeks, then monthly x 3 by nursing/ housekeeping. The results these audits will be presented to the Quality Committee for further recommendations. Date of completion is 9/07/15.	the #5. the ent and Se not cation x per y s of	

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	OMB NO. (X3) DATI	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245314	B. WING		07/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 254		ge 3 plained that even though it	F 2	54		
	was not R5's bath c	ay, the linen should have				
	director of nursing (brown smear on the	9:27 a.m., the consultant CDON) commented that the e sheet appeared to be fecal ne bed sheet should have				
F 282 SS=D	been changed. 483.20(k)(3)(ii) SEF	RVICES BY QUALIFIED	F 2	82		9/7/15
	must be provided b	led or arranged by the facility y qualified persons in ch resident's written plan of				
	This REQUIREMEN	NT is not met as vidence.				
	Based on observat review, the facility facility facility	tion, interview and document ailed to ensure collare plat of 3 resident. (R10, revidwed tin collarers		F282 Resident #10 had an and care plan review/update bruising on 8-21-15. All residents will have a skin completed, record review, an	related to check	
	Findings included:			appropriate care planning is o 8-28-15.	complete by	
	was prescribed an a medication known t	ed 5/24/15, directed staff R10 anticoagulant (blood thinning o contribute to bruising). ed monitoring for bruising.		Nursing staff will be educated policy and procedure for skin pressure ulcer prevention, an documentation requirements 8-27-15.For those not attendi	assessment, d by	
	discoloration and sk discoloration on the	to have several spots of skin kin tears to the right arm and e left forearm on 7/28/15, at wing day at 7:20 a.m. R10's		meeting, make up education completed by 9-7-15. Audits for weekly Documenta assessments will be complete	will be tion of skin	

Facility ID: 00961

If continuation sheet Page 4 of 14

	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION		. 0938-039 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				IPLETED
		245314	B. WING		07/	/30/2015
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 282	Continued From pa	age 4	F 282	2		
	director of nursing looked at R10's arr	At 9:07 a.m. the consultant (CDON) with the surveyor ns. The CDON verified the g and skin tears on the		DNS or designee. The results or audits will be presented to the Q Committee for further recommer Date of completion is 9/07/15.	uality	
	progress notes from no documentation The DON stated it	a.m. the CDON reviewed n 7/1/15 and verified there was related to R10's skin issues. was expected the NAs would nges to the charge nurse.				
	nurse (LPN)-A if sh left forearm or if R1 side when he recer	DON asked a licensed practical e noticed the bruising on the 0 had been found on his left ntly fell. LPN-A replied, "No nad noticed was after the fall	C			
	were the skin tears elbow and he was LPN-A was asked I	on the right arm and by the found on his right side "When by CDON if she hr a receive" as LPN-A denier receive of any				
	A nursing assistant a.m. R10 had expe she thought caused NA-A explained tha report any changes it had been reporte bruising had been	(NA)-A men eport d e' 3:40 rienc d a fal recently, which d the truis sand in tears. It the NA were supposed to a in skin co. Itions, but thought d and investigated, as the present on R10's arm since				
F 309 SS=D	Monday. 483.25 PROVIDE (HIGHEST WELL B	CARE/SERVICES FOR EING	F 309			9/7/15
	provide the necess	t receive and the facility must ary care and services to attain hest practicable physical, psocial well-being in				

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			FORM OMB NO.	: 11/02/2015 APPROVED .0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245314	B. WING _		07/	30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	Continued From pa accordance with the and plan of care.	ige 5 e comprehensive assessment	F 30	99		
	by: Based on observative review, the facility for related skin condition with observed bruiss Findings include: R10 had several sp skin tears to the rig the left forearm on following day at 7:2 tears to right forear forearm. At 9:07 a.1 nursing (CDON) wi R10's arms. The C bruising and skin te R10's care plan dat resident was presc thinning medication bruising). Interventive bruising. R10's 6/2/ Set (MDS) indicate impaired cognition. though 7/29/15, at 9:14 progress notes from no documentation of The DON stated it was presc	NT is not met as evidenced tion, interview and document ailed to identify non-pressure ons for 1 of 3 residents (R10) sing. bots of skin discoloration and ht arm and discoloration on 7/28/15, at 9:37 a.m. The 20 a.m. R10's bruises and skin m and bruise to the lo m. the consultant arector co. th the surveyor boked at DON verified be presence of ears on the resident starm ted 5 4/15, indicated are ribed in an accay cant (blood in known is contribute to ons inclued 1 monitoring for 15, quarterly Minimum Data d the resident had severely Progress Notes dated 7/1/15 vealed no documentation is in the resident's arms. • a.m. the CDON reviewed in 7/1/15 and verified there was related to R10's skin issues. was expected the NAs would inges to the charge nurse.		F309 Residen #10 had an ar Jessment and Lare plan revier elated to bit in g on 8-21-15. All residents will have a skin UD mew, ar Lensure appropriated plathing is complete by 9-07-15 in ursting staff will be educated or policy and procedure for skin as messure ulcer prevention, and documentation requirements by 8-27-15. For those not attending meeting, make up education will completed by 9-7-15. Audits on weekly Documentation assessments will be completed week x 4 weeks, then monthly x DNS or designee. The results of audits will be presented to the Q Committee for further recommendate Date of completion is 9/07/15.	A, record care the GSS sessment, the be of skin 3x per 3 by the f these uality	

If continuation sheet Page 6 of 14

		AND HUMAN SERVICES			FORM	: 11/02/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		245314	B. WING		07/	30/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 6	F 309			
	nurse (LPN)-A if sh left forearm or if R1 side when he recer The only thing we h were the skin tears elbow and he was f LPN-A was asked b any report of injurie reports. A nursing assistant a.m. R10 had expe she thought caused NA-A explained that report any changes it had been reported bruising had been p Monday. After the concern w attention, an incide the presence of a b measuring 4.5 x 3.0 A 5/15, Skin Assess Prevention And Doo policy under Assess Bruises/Contusions a bruise, contusion observed on a resid the nurse immediat tear/abrasion shoul any changes and/o should be documer	DON asked a licensed practical e noticed the bruising on the 0 had been found on his left http: fell. LPN-A replied, "No. had noticed was after the fall on the right arm and by the found on his right side." When by CDON if she had received is LPN-A denied receipt of any (NA)-A then reported at 9:40 rienced a fall recently, which d the bruises and skin tears. It the NAs were supposed to in skin conditions, but thought d and investigated, as the present on R10's arm ince was brought to the strus' int report dated a 2/15, no ed bruise of removes left present 0 cer interr (cm). Sment, a passure Ulcer cumentatic Requirements sment and Documentation of S/Skin tears/Abrasions read: "If , abrasion or skin tear is dent, this should be reported to refyThe bruise/contusion/skin d be monitored weekly and r progress toward healing need on the Skin Observation borym] and on the resident's				

If continuation sheet Page 7 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/02/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245314	B. WING		07/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 328	Continued From pa	ge 7	F 3	28		
F 328 SS=D	483.25(k) TREATM NEEDS	ENT/CARE FOR SPECIAL	F 3	28		9/7/15
	proper treatment ar special services: Injections; Parenteral and enter Colostomy, uretero Tracheostomy care Tracheal suctioning Respiratory care; Foot care; and Prostheses. This REQUIREMEN by: Based on observat review, the facility for positive airway press machine providing and mask were clear who utilized a CPAN Findings include: R5's room was obs a.m. A C-PAP mach attached to the nos bedside adjacent to	NT is not met as evidenced ion, interview and doc ment ailed to ensure the continue ssure (C-PAP heathing air for sleep a neal machine aned for 1 of 1 meants (*.5)		F328 Resident #5 CPAP m equipment has been cleaned. All residents that are on CPAP had their CPAP items cleaned. manufacturer ¿s direction for cl been added to the TAR to ensu cleaned daily / weekly per the recommendations. Care plans reviewed and updated as need Licensed staff will be educated following the manufactures recommendations on all reside CPAP by 8-27-15. For those n the meeting, make up education	have also The eaning has are they are have been ed. about nts with ot attending	
	continued to have a on the inside and the	a.m. C-PAP nasal piece mask a thick creamy/brown build up ne seams.		completed by 9-7-15. CPAP cleanliness audits will be weekly x 4 weeks, then monthl DNS or designee. The results audits will be presented to the Committee for further recomme	y x3 by the of these Quality	
	no nau a prysician	's order dated 10/13/11,		Date of completion 9/07/15		

Facility ID: 00961

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/02/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
		245314	B. WING _		07/:	30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	to obstructive sleep psychopharmacolog antidepressant med 4/10/14, directed st encouragement teo applying the C-PAP addition, direction w the C-PAP weekly. A 7/29/15, Admissio diagnoses including (complete or partial during sleep), insor stay asleep and nar wake cycles). A nursing assistant at 9:19 a.m. that the machine involved, " leave to dry." NA-C policy regarding cle At 9:27 a.m. the con (CDON) then verifie mask and acknowle at 10:15 a.m. the C have a policy for CF the manufacturer's A 9/12 C-PAP Thera "Please refer to the The manufacturer F instructions indicate cleaned daily and h warm soapy water.	night one time a day related apnea." A gical medication and dication care plan dated aff to provide sleep hniques which included machine mask at bedtime. In vas provided to staff to clean on Record revealed R5 had g obstructive sleep apnea blockage of upper airway nnia (inability to fall asleep or roolepsy (poor control of sleep (NA)-C explained on 7/29/15, e cleaning of R5's C `P General carerin @ out and was unsure of the facility aning of C-P. `machines. nsultan' aire for on surging ed de vis in 1 15's C AP edged 't wis not con an Later, DON reported, "I doubt we PAP cleaning." apy policy directed staff to manufacturer's instructions." Phillips Respironics 2014 ed masks should have been eadgear at least weekly in	F 32			9/7/15
F 334 SS=D	483.25(n) INFLUEN IMMUNIZATIONS	IZA AND PNEUMOCOCCAL	F 33	4		9/7/15

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		AND HUMAN SERVICES			FORM	D: 11/02/2015 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245314	B. WING		07	//30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 334	Continued From pa	ge 9	F 3	34		
	that ensure that (i) Before offering the each resident, or the representative rece- benefits and potent immunization; (ii) Each resident is immunization October annually, unless the contraindicated or to immunized during to (iii) The resident or representative has immunization; and (iv) The resident's re documentation that following: (A) That the resider representative was the benefits and po- immunization; and (B) That the resider influenza immunization; and (B) That the resider influenza immunization of The facility must det that ensure that (i) Before offering thi immunization; each legal representative the benefits and po- immunization; (ii) Each resident is immunization, unless	ives education regarding the ial side effects of the offered an influenza per 1 through March 31 e immunization is medically he resident has already been his time period; the resident's legal the opportunity to refuse medical record includes indicates, at a minimum, the ent or resident's legal provided educe ion renarding tential side enocts of influenza ent either receive the tion is did not receive the tion is to mean refusa.				

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ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		E SURVEY
ID PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG	COM	PLETED
		245314	B. WING		07/3	30/2015
IAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP		
GOOD SA	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 334	Continued From pa	age 10	F 3	34		
	already been immu	-				
		the resident's legal				
	representative has immunization; and	the opportunity to refuse				
		medical record includes				
	documentation that	t indicated, at a minimum, the				
	following:					
		ent or resident's legal provided education regarding				
		ptential side effects of				
	pneumococcal imn	nunization; and				
		ent either received the				
		nunization or did not receive immunization due to medical				
	contraindication or					
	(v) As an alternativ	e, based on an assessment				
		commendation, a second				
		nunization may be given after first pneumococcal				
		ss medically contr indicated or				
		resident's legal epresentative				
	refuses the second	l immunizatio				
		NT is numet as evidenced				
	by: Based on interview	v and document review, the		F 334 The pneumococo	al vaccino for	
		sure 1 of 5 residents (R41) was		F 334 The pneumococo Resident # 41 was review		
		eived pneumococcal		MD/NP and the recommen		
	vaccinations as rec	commended by Centers for		the vaccine is not indicate		
	Disease Control (C	EDC).		old female with no respirat		
	Findings include:			resident was informed and A review of all the resident		
				completed to ensure the p		
	P41's undeted Ada	nission Record indicated R41	1	pneumococcal vaccination		
		e facility on 10/3/14.		by 8-28-15. New admission		

Facility ID: 00961

If continuation sheet Page 11 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 11/02/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245314	B. WING _		07/	30/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 334 F 465 SS=D	documentation if a had been received, On 7/29/15, at 3:53 additional informatic administrator stated wasn't offered or gin don't know what wa I can't find risks or the Review of the Good Immunizations for F indicated that upon and/or legal represe Vaccination Information and pneumococcal potential side effect discussed with the indicated "if the resis pneumococcal vacco determine if it has the vaccination. Pneum indicated for those of years or longer since 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro- sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat	munization record lacked pneumococcal vaccination contraindicated or refused. p.m. when asked for on for R41's immunization the d "from what I understand it ven because of her age. I is said to her back in October. Denefits yet." d Samaritan Society Residents policy dated 2/15, admission, each resident entative will receive the ation Statements for influenza vaccines and the benefits a. d is of vaccinations will be resident. The policy (Liber ident received a cination before use 65 been five year since mat nococcal vaccination is residents in thas then we be primary vaccination	F 33	Licensed staff will be educated to they are offering the proper vacci admission by 8-27-15. For those attending the meeting, make up e will be completed by 9-7-15. Pneumor boom hudits will be com weekly or new admits x 4 weeks monthy, r3 by the INS or design results on these addits will be pre- ane Quality or unittee for further recommendations. In e of completion 9/07/15.	nes upon not education pleted then ee. The sented to	

Facility ID: 00961

If continuation sheet Page 12 of 14

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		0938-039 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		245314	B. WING		07/	30/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 465	Continued From pa	age 12	F 46	5		
	sanitary environment the potential to affer R4) who resided in during the environment Findings include: During an environm p.m., with the envir (ESS), the following were noted and ver On 7/28/15, R14's observed to be stat detected. During the and the need for cl clean it and if the s seat would be replat On 7/28/15, R5's b a strong odor in the tour ESS explained used a lot of toilet p garbage for the toil ESS also stated the pad in the garbage garbage, the bathro On 7/29/15, ESS in clipboard, located a staff to write enviro stated the cleaning rooms and toilets w On 7/30/15, at 9:08 nursing assistant (f	Ant was maintained, which had bet 3 of 28 residents (R14, R5, resident rooms observed mental tour. An ental tour on 7/29/15, at 1:31 commental services supervisor g environmental concerns rified: toilet seat, behind risers, was ined and an odor was the tour ESS verified the stain eaning. ESS stated staff world tain did not come off, the toil ' aced. athroom was observed to ne re- e shared bathre in. During the d that R5's roommate (R4) paper and used is oathre in et pape, instad of the cilet. at R5 arrows he incomment and is that the maintenance at the nurse's station, was for inmental concerns. ESS also is schedule for cleaning all		cleaned as appropriate. All residents have the potentia affected by this same deficient All resident rooms were inspe- ensure a clean and sanitary of by 8-28-17. Nursing, houseke ping, and enviror, general ser de staff w er acateo in the CSS Policy a procedure to be clean and sa environment and a cleaning s of mplemanted by 8-28-15. Not, the ding the meeting, ma fucation will be completed b E vironmental audits will be of weekly x 4 weeks, then month DNS/ESS or designee. The of these audits will be presented Quality Committee for further recommendations. Date of completion 9/07/15.	at practice. ected to environment ill be and initary ichedule will For those ake up by 9-7-15. completed hly x3 by the results of I to the	

If continuation sheet Page 13 of 14

		AND HUMAN SERVICES				FORM	: 11/02/2015 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245314	B. WING	ì		07/:	30/2015
NAME OF	PROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- WINTHROP			506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	clipboard. At 9:17 a licensed practical m an environmental c the clipboard and if The facility cleaning dated December 20 "3. All parts of the neat and free of little as necessary to ke free of accumulatio	e concern on the maintenance a.m., when interviewed, the jurse (LPN)-B stated if she had concern she would write it on recessary, would call them. g of common areas policy 008, revised 6/14, indicated: e community will be kept clean, er. 7. Clean surfaces as often ep furniture and equipment ons of dust, dirt, food particles, proom wastebaskets daily or as	F	465			

Facility ID: 00961

If continuation sheet Page 14 of 14

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245314	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/14/2015
Name of Facility			Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - WINTHROP			506 HIGH STREET WINTHROP, MN 55396	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0246	(Correction Completed 09/07/2015	ID Prefix	F0254		Correction Completed 09/07/2015		ID Prefix	F0282		Correction Completed 09/07/2015
	483.15(e)(1)				483.15(h)(3)					483.20(k)(3)(ii		
ID Prefix Reg. # LSC	F0309 483.25	(Correction Completed 09/07/2015	ID Prefix Reg. # LSC	F032P 483.25(k)		nr stion Co lot ^/07/zu15		ID Prefix Reg. # LSC	F0334 483.25(n)		Correction Completed 09/07/2015
ID Prefix Reg. # LSC	F0465 483.70(h)	(Correction Completed 09/07/2015	ID'efix F.∵.,r L.			Correction Completed					Correction Completed
ID Prefix Reg. # LSC			Correctic Completed	ID Prefix Reg. # LSC			Correction Completed		Reg. #			Correction Completed
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed		D //			
Reviewed I	Зу П	eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
State Agen	cy G	D/kfd		11/02/201	5		1	8623				09/14/2015
Reviewed I CMS RO	Зу В	eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
Followup	o Survey Comp 7/30/2				Check for any Uncorrected					Summary of the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0003 4738 3285

November 2, 2015

Mr. Marcus Parence, Administrator Good Samaritan Society - Winthrop 506 High Street Winthrop, MN 55396

Subject: Good Samaritan Society Winthrop Provider # 245314 Project # \$4302

Dear Mr. Parence:

This is in response to your letter received on, August 21st, 2015, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tag F428 where corresponding correction orders were issued pursuant to the survey completed on July 30, 2015.

The information presented with your letter, the CMS and State 2567s dated July 30, 2015, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

State Tag ID Prefix – 1530 Drug Regimen Review: The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy.

- This is not a valid correction order and will be removed from the 2567 State Form.
- The revised 2567 State Form is attached.

This concludes the Minnesota Department of Health informal dispute resolution process where corresponding correction orders were issued.

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

Good Samaritan Society - Winthrop November 2, 2015 Page 2

Sincerely,

Sail anderson

Gail Anderson, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 218-332-5140 Fax: 218-332-5196

 cc: Office of Ombudsman for Long-Term Care Pam Kerssen, Assistant Program Manager Licensing and Certification File Gloria Derfus, Metro C District Office Unit Supervisor

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00961	B. WING		07/3	80/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP 506 HIGH WINTHRO	STREET DP, MN 5539	96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing conny assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	Department's staff, the following correct corrections are com make a copy of the original to the Minne Division of Complia	FS: v 30th 2015, surveyors of this visited the above provider and tion orders are issued. When pleted, please sign and date, se orders and return the esota Department of Health, nce Monitoring, Licensing and				
_ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 08/22/15

If continuation sheet 1 of 13

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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2 000	Continued From pa	age 1	2 000			
	Certification Progra MN 55164-0900.	um, P.O. Box 64900 St. Paul,				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			9/7/15
		omprehensive plan of care I personnel involved in the t.		, Ò		
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure a care plan of 3 residents (R10) reviewed kin concerns.		Currected		
	Findings included:					
	was prescribed an medication known	ted 5/24 ، 5, dir oted حيات ، 0 antic ، gulant , lood thinning to con, hute ، ويتان من الم led mon, ing for bruising.				
	discoloration and s discoloration on the 9:37 a.m. The follow bruises and skin te	to have several spots of skin kin tears to the right arm and e left forearm on 7/28/15, at wing day at 7:20 a.m. R10's ars to right forearm and bruise At 9:07 a.m. the consultant	9			
	looked at R10's arr	(CDON) with the surveyor ns. The CDON verified the g and skin tears on the				
	On 7/29/15, at 9:14	a.m. the CDON reviewed				

Minneso	ta Department of He	ealth			1 01 101	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00961	B. WING		07/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP 506 HIGH WINTHROP	STREET	96		
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2 565	no documentation r The DON stated it v report any skin cha At 9:26 a.m. the CE nurse (LPN)-A if sh left forearm or if R1 side when he recer The only thing we h were the skin tears elbow and he was f LPN-A was asked b any report of injurie reports. A nursing assistant a.m. R10 had expe she thought caused NA-A explained tha report any changes it had been reported bruising had been p Monday.	n 7/1/15 and verified there was related to R10's skin issues. was expected the NAs would nges to the charge nurse. DON asked a licensed practical e noticed the bruising on the 0 had been found on his left titly fell. LPN-A replied, "No. had noticed was after the fall on the right arm and by the found on his right side." When by CDON if she had received the LPN-A denied receipt of any (NA)-A then reported at 9:40 rienced a fall recently, which d the bruises and skin tears. It the NAs were supported to a in skin conditions, full the ught d and investigated, still present c R1 still arm since				
	(s)could review and procedures related each individual resi of nursing or design to educate staff and to ensure staff are the written plan of o					
Vinnesota D	TIME PERIOD FOR epartment of Health	R CORRECTION: Twenty-one				

TAG FEGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE 2 565 Continued From page 3 (21) days. 2 565 2 565 9/7/15 2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 2 830 9/7/15 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. Corrected This MN Requirement is not met as e den ad by: Based on observation, inte new a dout me- review, the facility failed videntif non-pressure related skin conditions for. of result. With observed bruising and vid to ensure the continuous positive airway prev ure (C-PAP breathing machine providing air vid seep apnea) machine and mask were cleaned for 1 of 1 Corrected	Minnesc	ta Department of He	ealth				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - WINTHROP SOB HIGH STREET WINTHROP, INN 55396 (V4) ID PHEEN TXG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST DE PRECIEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PHEEN TXG PROVIDER'S PLAN OF CORRECTION (EACH CORPRECTIVE ACTION SHOULD BE (EACH OCRECTIVE ACTION SHOULD BE (EAC							
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GOOD SAMARTIAN SOCIETY - WINTHROP WINTHROP, MN 55396 Image: Carton Enclosed of the second of the s	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE DATE 2 565 Continued From page 3 (21) days. 2 565 2 565 2 830 MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 2 830 2 830 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident musts there is a written order from the attending physician that the resident must remain in bed. 2 830 9/7/15 This MN Requirement is not met as e den ad by: Based on observation, inte new a dou mer review, the facility failed i identif non-pressure related skin conditions fo. of resuue. Mit boserved bruising and a do to ensure the continuous positive airway pre, ure (C-PAP breathing machine providing air v. sleep apnea) machine and mask were cleaned for 1 of 1 Corrected	GOOD S	AMARITAN SOCIETY			96		
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Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as e denoded by: Based on observation, internew aid dociment review, the facility failed or identific mon-pressurer related skin conditions for of resource (R10) with observed bruising and red to ensure the continuous positive airway prequire (C-PAP breathing machine providing air nur sleep apnea) machine and mask were cleaned for 1 of 1		(21) days.					
 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as e denoted by: Based on observation, interview and document review, the facility failed or identific non-pressure related skin conditions for of resident. (R10) with observed bruising and we do ensure the continuous positive airway preview (C-PAP breathing machine providing air worshee papnea) machine and mask were cleaned for 1 of 1 	2 830			2 830			9/7/15
residents (R5) who utilized a CPAP machine. Findings include: R10 had several spots of skin discoloration and skin tears to the right arm and discoloration on the left forearm on 7/28/15, at 9:37 a.m. The following day at 7:20 a.m. R10's bruises and skin tears to right forearm and bruise to the left forearm. At 9:07 a.m. the consultant director of		receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t resident must rema prefers to remain in This MN Requirem by: Based on observat review, the facility f related skin conditi- with observed bruis continuous positive breathing machine machine and mask residents (R5) who Findings include: R10 had several sp skin tears to the rig the left forearm on following day at 7:2 tears to right forear	re and treatment, personal and supervision based on ad preferences as identified in eresident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed. ent is not met as e denod ion, internew a d docment failed didentif non-pressure ons for of resident (R10) sing and dot do ensure the e airway presture (C-PAP providing air to sleep apnea) a were cleaned for 1 of 1 outilized a CPAP machine.		Corrected		
Minnesota Department of Health	Minnesota D	epartment of Health					

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00961	B. WING		07/3	0/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- WINTHBOP 506 HIGH				
		WINTHRO	OP, MN 5539			1
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2 830	Continued From pa	age 4	2 830			
	R10's arms. The C	ith the surveyor looked at DON verified the presence of ears on the resident's arms.				
	resident was presc thinning medication bruising). Intervent bruising. R10's 6/2. Set (MDS) indicate impaired cognition. though 7/29/15, rev related to alteration On 7/29/15, at 9:14 progress notes from no documentation The DON stated it report any skin cha At 9:26 a.m. the CI nurse (LPN)-A if sh left forearm or if R ⁻ side when he recent The only thing we have were the skin tears elbow and he was LPN-A was asked any report of injurier reports. A nursing assistant a.m. R10 had expension she thought caused NA-A explained that report any changes it had been reported	ted 5/24/15, indicated the pribed an anticoagulant (blood in known to contribute to ions included monitoring for /15, quarterly Minimum Data ed the resident had severely Progress Notes dated 7/1/15 vealed no documentation is in the resident's arms. A a.m. the CDON reviewed m 7/1/15 and verified there was related to R10's skin issues. was expected the NAs would anges to the charge nurse. DON asked a licens of premical ne noticed the bruising remthe 10 had be and to ind on his left notified the bruising remthe 10 had be and to ind on his left notified the bruising remthe found on his right side." When by CDON if sight and received es LPN-A denied receipt of any at the NAs were supposed to s in skin conditions, but thought and investigated, as the present on R10's arm since				
Minnesota D	epartment of Health					

Minnesc	ota Department of He	alth				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE S COMPL	
		00961	B. WING		07/30	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		I STREET OP, MN 553	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 5	2 830			
	After the concern w attention, an incide the presence of a b measuring 4.5 x 3.0 A 5/15, Skin Assess Prevention And Doo policy under Assess Bruises/Contusions a bruise, contusion observed on a resid the nurse immediat tear/abrasion shoul any changes and/o should be documer	vas brought to the staffs' nt report dated 7/29/15, noted pruise on R10's left forearm				
Minnesota D	a.m. A C-PAP mach attached to the nos bedside adjacent to creamy white/brown mask and around th On 7/29/15, at 8:20 continued to have a on the inside and th R5 had a physician directing "C-PAP at to obstructive sleep psychopharmacolo antidepressant med 4/10/14, directed st encouragement teo applying the C-PAF	a.m. C-Pr `nasal piece mask a thick cream, `rown build up ne seams. 's order dated 10/13/11, night one time a day related o apnea." A gical medication and dication care plan dated				

Minneso	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00961	B. WING		07/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP 506 HIGH WINTHROP	STREET DP, MN 5539	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	diagnoses including (complete or partial during sleep), insor stay asleep and nar wake cycles). A nursing assistant at 9:19 a.m. that the machine involved, ' leave to dry." NA-C policy regarding cle At 9:27 a.m. the co (CDON) then verifie mask and acknowle at 10:15 a.m. the C have a policy for Cf the manufacturer's A 9/12 C-PAP Ther. "Please refer to the The manufacturer f instructions indicate cleaned daily and h warm soapy water. SUGGESTED MET The director of nurs and revise policies/ monitor to assure re are appropriately m	apy policy directed haff to manufacture instructions Phillip Respire ics 2014 ed maths show to been eadgeat reast weekly in THOD OF CORRECTION: sing or designee, could review procedures, train staff and esidents and their equipment onitored. The director of				
	ensure appropriate	e could develop an audit tool to care is provided. R CORRECTION: Twenty-one				
Minnesota D	(21) days. epartment of Health	·				
STATE FOR	•		6899 2	2CND11	If continuati	on sheet 7 of 13

Minnesc	ta Department of He	alth				ATTIOVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00961	B. WING		07/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP 506 HIGH WINTHRO	STREET DP, MN 5539	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
	The following items resident: A. A bed of pro convenience of the mattress, and clear weather and reside condition. Each be bedspread. A mois mattress cover mus confined to bed and Rollaway type beds not be used. B. A chair or pla than the bed. C. A place adja personal possessio with a drawer. D. Clean bath I often as needed. E. A bed light conv intensity to meet the in bed or in an adja This MN Requirement by: Based on observati review the facility factors	ent is not n. `as evidenced on, interview and document iled to ensure clean and	21670	Corrected		9/7/15
	of 1 resident (R5) re living.	were provided as needed for 1 eviewed for activites of daily				
	Findings included:					
	observations the fit large brown smear,	8 a.m. during R5's room ted sheet was noted to have a by the right grab bar.				
Minnesota D STATE FOR	epartment of Health M		6899	2CND11	If continuati	on sheet 8 of 13

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00961	B. WING		07/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- WINTHROP	I STREET			
		WINTHR	OP, MN 5539	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21670	Continued From pa	age 8	21670			
21695	 wheeled to the dini the meal, at 8:20 a was transferred ba into the recliner cha fitted sheet on R5's large brown smear On 7/29/15, at 9:22 (LPN)-B, during a s verified the brown s grab bar. LPN-B ey was not R5's bath been changed. LPI nursing assistant c During interview, a director of nursing brown smear on th matter and stated t been changed. SUGGESTED ME⁻ The Director of Nur policies/procedures monitor to assure to residents use. TIME PERIOD FO (21) days. MN Rule 4658.141 Housekeeping, Op Subp. 4. Houseke 	t 9:27 a.m., the consultant (CDON) commented that m. e sheet appeared to be focal the bed sheet should nave THOD C. ORRECTION: rsing or deleme could review s, provide state raining and bed linens are clean for the R CORRECTION: Twenty-one 5 Subp. 4 Plant eration, & Maintenance seping. A nursing home must	21695			9/7/15
Minnosoto	provide housekeep	ing and maintenance services				
STATE FOR			6899	2CND11	lf continuati	on sheet 9 of 13

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:	A. BUILDING:		
		00961	B. WING		07/3	30/2015
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- WINTHROP	H STREET OP, MN 5539	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From pa	age 9	21695			
	comfortable interio	ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,				
	by: Based on observat review, the facility f sanitary environme the potential to affe	ent is not met as evidenced ion, interview and document ailed to ensure a clean and ent was maintained, which had ect 3 of 28 residents (R14, R5, resident rooms observed nental tour.	C	Correctec		
	Findings include:					
	p.m., with the envir	nental tour on 7/29/15, at 1:31 onmental services supervis g environmental concerns rified:				
	observed to be stat detected. During th and the need for cl	eaning. Stated staff would tain did no. Ome off, the toilet				
	a strong odor in the tour ESS explained used a lot of toilet p garbage for the toil ESS also stated that	athroom was observed to have e shared bathroom. During the d that R5's roommate (R4) paper and used the bathroom et paper, instead of the toilet. at R5 throws the incontinent and if staff doesn't empty the pom has an odor.				
		dentified that the maintenance at the nurse's station, was for				

Minneso	ta Department of He	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		00961	B. WING		07/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP	I STREET OP, MN 5539	96		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 10	21695			
		nmental concerns. ESS also schedule for cleaning all as daily.				
	nursing assistant (N environmental conc environmental servi notify the charge nu she would write the clipboard. At 9:17 a licensed practical n an environmental co	a.m. when interviewed, JA)-B stated if she had an eern, she would notify ices. If unavailable, she would irse. If neither were available, concern on the maintenance .m., when interviewed, the urse (LPN)-B stated if she had oncern she would write it on ecessary, would call them.	C			
	dated December 20 "3. All parts of the neat and free of little as necessary to kee free of accumulatio	g of common areas policy 008, revised 6/14, indicated: community will be kept clean, er. 7. Clean surfaces as once p furniture and equipment ns of dust, dirt, foor partiries, room wastebasket deivor s s neede.				
	bathroom toilets are that bathrooms are procedures could b					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21810	MN St. Statute 144 Residents of HC Fa	651 Subd. 6 Patients & ac.Bill of Rights	21810			9/7/15
		iate health care. Patients and				
Minnesota D STATE FORI	epartment of Health M		6899 2	2CND11	If continuatio	n sheet 11 of 13

N

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	COM	COMPLETED		
		00961	B. WING		07/3	30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET OP, MN 55396	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21810	Continued From pa	age 11	21810			
	medical and person needs. Appropriate care designed to e highest level of phy This right is limited	e the right to appropriate nal care based on individual e care for residents means nable residents to achieve thei vsical and mental functioning. where the service is not ublic or private resources.	r			
	by: Based on observat review, the facility f within reach for 1 c	ent is not met as evidenced ion, interview and document failed to ensure a call light was of 1 resident (R46) whose call ch during a specialized	C	Culotter		
	awake sitting up in pumps on both leg hanging on R46's g should the resident staff. A licensed pra the room and the re pointed out to the L not within reach" at armrest. LPN-A sta been within the res	a.m., R46 was obs ved be his recliner with an ric s. The crough, ord is grable and no within reach thave bede in the recliner actical n. (LPN)-A entered esident's collight position was LPN. LPN-A sited, "No, it is not moved it to the recliner atted the call light should have ident's reach, and R46 stated h and use the call light.				
	indicated R46 had The corresponding analysis dated 6/14 assistance with act including bed mobi personal hygiene.	linimum Data Set dated 6/9/15 moderately impaired cognition Care Area Assessment (CAA) I/15, revealed R46 required ivities of daily living (ADLs) lity, dressing, toileting and The CAA indicated resident	·			
innesota De FATE FORM	personal hygiene.		6899 20	CND11	If continuatio	on sheet

Minnesc	ta Department of He	alth				
		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00961	B. WING		07/3	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP 506 HIGH WINTHRO	STREET OP, MN 5539	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 12	21810			
	was at risk for falls related to difficulty maintaining sitting balance and impaired balance during transitions.					
	had an ADL self-ca required cues for pr plan also indicated related to weakness and modify environ have caused or cor On 7/28/15, at 9:55	a.m. LPN-A stated when I pumps on his legs he should	C			
	consultant director when resident was should have been w in bed or in the cha A 9/12, Call Light pu leaving the room, p reach of resident if call light cord across reach it."	rocedure aired d ster "When lace chailight vithin easy in beaufout in the stretch s bed sensident is able to THOD OF CORRECTION:				
	that policy and proc staff are trained and	sing or designee could assure redures are up to date, that d that call lights are monitored n reach and accessible to the				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
Minnesota D	epartment of Health					

DEPARTMENT OF HEA	MEDICA	ARE/MEDICAL			CENTERS FOR MEI AND TRANSMITTAL TE SURVEY AGENCY	DICARE & MEDICAID SERVICES ID: 2CND Facility ID: 00961
1. MEDICARE/MEDICAID PROV (L1) 245314 2.STATE VENDOR OR MEDICA (L2) 841820900	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - V (L4) 506 HIGH STREET (L5) WINTHROP, MN			VINTHROP (L6) 55396	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. Or Dr. W.	
 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 09/14/2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other 		7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD 02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/II 04 SNF 08 OPT/SP 12 RHC		02 (L7) 13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31	
 11. LTC PERIOD OF CERTIFICAT From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	TION 37 (L18) 37 (L17)	Complianc 1. A B. Not in Con		ram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
14. LTC CERTIFIED BED BREAI	KDOWN	Kequitein			: * Code: A* 15. FACILITY MEETS	
18 SNF 18/19 S	NF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY R	EMARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION 1	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Gloria Derfus, Unit S</u>	upervisor	1	0/15/2015	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 10/26/2015 (L20)
	PART II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	STATE AGENCY
 DETERMINATION OF ELIG <u>X</u> 1. Facility is Eligible 2. Facility is not Eli 	to Participate		IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 05/01/1986	BEGINNINC	5 DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	8
A. Suspensio		IVE SANCTIONS n of Admissions: (L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	07-Provider Status Change 00-Active	
	B. Reschiu Si	spension Date:	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE		
	(L32)	09/10/2015		(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245314

October 26, 2015

Mr. Marcus Parence, Administrator Good Samaritan Society - Winthrop 506 High Street Winthrop, Minnesota 55396

Dear Mr. Parence:

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 the above facility is certified for:

37 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 37 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 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, Program Specialist Licensing and Certification Program Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 15, 2015

Mr. Marcus Parence, Administrator Good Samaritan Society - Winthrop 506 High Street Winthrop, Minnesota 55396

RE: Project Number F5314024

Dear Mr. Parence:

On September 30, 2015, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 30, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of September 30, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 30, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on July 30, 2015, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our notice. The most serious health deficiencies in your facility at the time of the standard survey 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) whereby corrections were required.

On October 5, 2015, the Minnesota Department of Life Safety (LSC) completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 30, 2015, as of October 3, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of September 30, 2015. The CMS Region V Office concurs and has authorized this Department

Good Samaritan Society - Winthrop October 14, 2015 Page 2

to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 30, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 30, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 30, 2015, is to be rescinded.

In our letter of September 30, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 30, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 3, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske. Downing

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 30, 2015

Mr. Marcus Parence, Administrator Good Samaritan Society - Winthrop 506 High Street Winthrop, Minnesota 55396

RE: Project Number S5314024

Dear Mr. Parence:

On August 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 30, 2015. 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 September 14, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 7, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on July 30, 2015.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the July 30, 2015 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey 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) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 30, 2015. (42 CFR 488.417 (b))

Good Samaritan Society - Winthrop September 25, 2015 Page 2

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 30, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 30, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Winthrop is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 30, 2015. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

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 <u>https://dab.efile.hhs.gov</u> 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:

Jan.Suzuki@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. Good Samaritan Society - Winthrop September 25, 2015 Page 3

Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

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 January 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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.

Good Samaritan Society - Winthrop September 25, 2015 Page 4

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245314	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/14/2015
Name of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - V	/INTHROP	506 HIGH STREET WINTHROP, MN 55396	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) It	em		(Y5)	Date
ID Prefix Reg. # LSC	483.15(e)(1)	Correction Completed 09/07/2015		F0254 483.15(h)(3)	Correction Completed 09/07/2015		Reg. #	F0282 483.20(k)(3)(ii		Correction Completed 09/07/2015
ID Prefix Reg. # LSC	492.05	Correction Completed 09/07/2015	ID Prefix	F0328	Correction Completed 09/07/2015		D Prefix Reg. #	F0334 483.25(n)		Correction Completed 09/07/2015
	F0428 483.60(c)	Correction Completed 09/07/2015		F0465 483.70(h)	Correction Completed 09/07/2015		Reg. #			
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC				Reg. #			
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC				D Prefix Reg. # LSC			
Reviewed I State Agen	-	Reviewed By GD/kfd	Date: 10/15/20	-	of Surveyor:	8623			Date:	9/14/2015
Reviewed I CMS RO	Ву	Reviewed By	Date:	Signature	of Surveyor:				Date:	
Followup	to Survey Com 7/30/2	-			/ Uncorrected Defi d Deficiencies (CM				YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245314	(Y2) Multiple Cons A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 10/5/2015
Name of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - WINTH	HROP	506 HIGH STREET WINTHROP, MN 55396	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix			Correction Completed 09/07/2015	ID Prefix			Correction Completed 10/03/2015		ID Prefix			Correction Completed 09/07/2015
	NFPA 101 K0018			0	NFPA 101 K0027				-	NFPA 101 K0050		
-	NFPA 101 K0054		Correction Completed 09/07/2015	Reg. #	NFPA 101 K0056		Correction Completed 09/07/2015		Reg. #	NFPA 101 K0062		Correction Completed 09/07/2015
Reg. #	NFPA 101 K0067		Correction Completed 09/07/2015	Reg. #	NFPA 101 K0069		Correction Completed 09/07/2015					
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		ID Prefix Reg. # LSC			Correction Completed
Reg. #			Correction Completed	Reg. #								
Reviewed I		Reviewed	Ву	Date:	Signature	e of Sur	veyor:				Date:	
State Agen Reviewed I CMS RO		GS/kfd Reviewed	Ву	10/15/201 Date:	5 Signature	e of Sur		764			Date:	10/05/2015
Followup	o Survey Com 7/28/2	-	:							Summary of the Facility?	YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245314	(Y2) Multiple Cons A. Building B. Wing	6 ADDITION	(Y3) Date of Revisit 10/5/2015			
Name of Facility		Street Address, City, State, Zip Code				
GOOD SAMARITAN SOCIETY - WINTH	IROP	506 HIGH STREET WINTHROP, MN 55396				

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix		(Correction Completed 09/07/2015	ID Prefix			Correction Completed 09/07/2015		ID Prefix			Correction Completed 09/07/2015
	NFPA 101	,			NFPA 101					NFPA 101		
	K0018			-	K0029				0	K0050		
		(Correction				Correction					Correction
ID Prefix			Completed 09/07/2015	ID Prefix			Completed 09/07/2015		ID Prefix	_		Completed 09/07/2015
Reg. #	NFPA 101			Reg. #	NFPA 101				Reg. #	NFPA 101		
	K0054				K0062				LSC	K0067		
ID Prefix		(Correction Completed	ID Prefix			Correction Completed		ID Prefix			Correction Completed
Reg. #				Reg. #					Reg. #			
ID Prefix Reg. #			Correction Completed				Correction Completed					
LSC				LSC					LSC			
Reg. #			Correction Completed	Reg. #					Б ″			
Reviewed I	Ву Р	Reviewed	Ву	Date:	Signature	e of Sur	veyor:				Date:	
State Agen	cy (GS/kfd		10/15/20	15		3	476	4		10/0	5/2015
Reviewed I CMS RO	Ву F	Reviewed	Ву	Date:	Signature	e of Sur	veyor:				Date:	
Followup t	o Survey Com 7/28/2									Summary of the Facility?	YES	NO

DEPARTMENT OF H	MEDICA	ARE/MEDICAI			CENTERS FOR MEI AND TRANSMITTAL TE SURVEY AGENCY	DICARE & MEDICAID SERVICES ID: 2CND Facility ID: 00961
1. MEDICARE/MEDICAID (L1) 245314 2.STATE VENDOR OR MEI (L2) 841820900	PROVIDER NO.	3. NAME AND AI (L3) GOOD SAM (L4) 506 HIGH S (L5) WINTHRO	DDRESS OF FAC IARITAN SOC TREET	CILITY		4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
 5. EFFECTIVE DATE CHAR (L9) 6. DATE OF SURVEY 8. ACCREDITATION STAT 0 Unaccredited 2 AOA 	07/30/2015 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/II 12 RHC	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
 11LTC PERIOD OF CERTIN From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 	FICATION 37 (L18) 37 (L17)	Complianc 1. A X B. Not in Con	nce With equirements e Based On: .cceptable POC npliance with Pros	ram	2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director
	57 ()	Requirem	ents and/or Appli	ed Waivers	: * Code: B *	(L12)
14. LTC CERTIFIED BED BI		ICE	IID		15. FACILITY MEETS	(L15)
	/19 SNF 19 SNF 37 (L38)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(113)
16. STATE SURVEY AGEN	CY REMARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION 1	DATE):		
17. SURVEYOR SIGNATUR	RE	Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Rebecca Wong, H	IFE NE II	(08/25/2015	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 09/04/2015 (L20)
	PART II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF 1 1. Facility is El 2. Facility is no 	igible to Participate		IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
22. ORIGINAL DATE	23. LTC AGREE	MENT 2-	4. LTC AGREEN	1ENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 05/01/1986	BEGINNINC	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure 00	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	8
25. LTC EXTENSION DAT	A. Suspension	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatic 04-Other Reason for Withdrawal	07-Provider Status Change 00-Active
		1	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1	539 32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 13, 2015

Mr. Marcus Parence, Administrator Good Samaritan Society - Winthrop 506 High Street Winthrop, Minnesota 55396

RE: Project Number S5314024

Dear Mr. Parence:

On July 30, 2015, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not

attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 8, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 8, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 October 30, 2015 (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). This mandatory denial of

payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 January 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

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

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ATE SURVEY OMPLETED
		245314	B. WING		7/30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 506 HIGH STREET	
GOOD S	AMARITAN SOCIETY	- WINTHROP		WINTHROP, MN 55396	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 000	INITIAL COMMEN	TS	F 000		
	as your allegation of Department's acce enrolled in ePOC, at the bottom of the form. Your electro	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.			
F 246 SS=D	on-site revisit of yo validate that substa regulations has be your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with SONABLE ACCOMMODATION ERENCES	F 246	5	9/7/15
	services in the faci accommodations of preferences, except	right to reside and receive lity with reasonable of individual needs and ot when the health or safety of her residents would be			
	by: Based on observa review, the facility f within reach for 1 of light was out of rea treatment. Findings include: On 7/28/15 at 9:55	NT is not met as evidenced tion, interview and document failed to ensure a call light was of 1 resident (R46) whose call ich during a specialized a.m., R46 was observed to be his recliner, with arterial		F246 Resident #46 was given his call light at the time it was brought to staff attention that it was not within his reach. All residents are identified as having the potential to be affected by this deficient practice. All staff will be educated on the need to make sure residents in their rooms can reach their call lights by 8-27-15. For those not attending the meeting, make u	

Electronically Signed

08/22/2015

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.

						. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · /	E SURVEY IPLETED
		245314	B. WING		07/	/30/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 246	pumps on both leg hanging on R46's g should the resident staff. A licensed pro- the room and the re- pointed out to the L not within reach" at armrest. LPN-A sta- been within the resc he could then reac R46's admission M indicated R46 had The corresponding analysis dated 6/14 assistance with act including bed mobil personal hygiene. was at risk for falls sitting balance and transitions. R46's care plan da had an ADL self-car required cues for p plan also indicated related to weakness and modify environ have caused or co On 7/28/15, at 9:55 resident had arteria use call light for as On 7/28/15, at 10:50 consultant director when resident was	s. The call light cord was grab bar and not within reach t have needed assistance from actical nurse (LPN)-A entered esident's call light position was LPN. LPN-A stated, "No, it is nd moved it to the recliner ated the call light should have ident's reach, and R46 stated h and use the call light. Linimum Data Set dated 6/9/15, moderately impaired cognition. Care Area Assessment (CAA) 4/15, revealed R46 required tivities of daily living (ADLs) lity, dressing, toileting and The CAA indicated resident related to difficulty maintaining impaired balance during ted 6/2/15, indicated resident are performance. The care resident was at risk for falls as. Staff was directed to review amental hazards that could ntributed to falls. 5 a.m. LPN-A stated when al pumps on his legs he should sistance. 59 a.m. when asked the of nursing (CDON) stated in his room, the call light within reach whether R46 was	F 24	6 education will be completed by Call light audits will be complete week x 4 weeks, then monthly DNS or designee. The results audits will be presented to the 0 Committee for further recomme Date of completion is 9/07/15.	ed 3x per k3 by the of these Quality	

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		AND HUMAN SERVICES		FO	ED: 08/25/2015 RM APPROVED NO. 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		DATE SURVEY COMPLETED
		245314	B. WING _		07/30/2015
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 246	Continued From pa	ige 2	F 24	6	
F 254 SS=D	leaving the room, p reach of resident if call light cord acros reach it." 483.15(h)(3) CLEA GOOD CONDITION	ovide clean bed and bath	F 25	4	9/7/15
	by: Based on observative review the facility fast sanitary bed linenss of 1 resident (R5) reliving. Findings included: On 7/28/15, at 10:00 observations the fit large brown smear, On 7/29/15 at 7:20 wheeled to the dinity the meal, at 8:20 a. was transferred back into the recliner char fitted sheet on R5's large brown smear, On 7/29/15, at 9:22 (LPN)-B, during a statement of the section of the	NT is not met as evidenced tion, interview and document ailed to ensure clean and were provided as needed for 1 eviewed for activites of daily 88 a.m. during R5's room ted sheet was noted to have a , by the right grab bar. a.m. R5 was observed to be ng room in a wheelchair. After m., with staff assistance R5 ck to her room and assisted air. During this observation, the bed was still soiled with a , up near the bed rail.		F254 The bed linens were changed immediately upon being notified that the bed linens were soiled for Resident #5. All residents are identified as having the potential to be affected by this deficient practice. Bed linens were checked and changed as appropriate on 8-20-15. All staff will be educated on the GSS policy and procedure for resident environment by 8-27-15. For those no attending the meeting, make up educat will be completed by 9-7-15. Bed linen audits will be completed 3x p week x 4 weeks, then monthly x 3 by nursing/ housekeeping. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion is 9/07/15.	e I ot ion er

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION (X	3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG	COMPLETED
		245314	B. WING _		07/30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 254	grab bar. LPN-B ex was not R5's bath of been changed. LPN nursing assistant ch During interview, at director of nursing (brown smear on the	plained that even though it day, the linen should have N-B stated she would have the	F 25	4	
F 282 SS=D	PERSONS/PER CA The services provic must be provided b	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in th resident's written plan of	F 28	2	9/7/15
	by: Based on observat review, the facility fa was followed for 1 of for non-pressure sk Findings included: R10's care plan dat was prescribed an a medication known t Interventions includ R10 was observed discoloration and sk discoloration on the 9:37 a.m. The follow	NT is not met as evidenced tion, interview and document ailed to ensure a care plan of 3 residents (R10) reviewed kin concerns. ted 5/24/15, directed staff R10 anticoagulant (blood thinning to contribute to bruising). led monitoring for bruising. to have several spots of skin kin tears to the right arm and e left forearm on 7/28/15, at wing day at 7:20 a.m. R10's ars to right forearm and bruise		F282 Resident #10 had an assessm and care plan review/update related to bruising on 8-21-15. All residents will have a skin check completed, record review, and ensure appropriate care planning is complete 8-28-15. Nursing staff will be educated on the policy and procedure for skin assessm pressure ulcer prevention, and documentation requirements by 8-27-15.For those not attending the meeting, make up education will be completed by 9-7-15. Audits for weekly Documentation of s assessments will be completed 3x pe week x 4 weeks, then monthly x3 by t	o e e by GSS nent, kin r

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						0938-039
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY IPLETED
		245314	B. WING		07/	30/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	to the left forearm. director of nursing looked at R10's arr presence of bruisin resident's arms. On 7/29/15, at 9:14 progress notes from no documentation The DON stated it report any skin cha At 9:26 a.m. the CI nurse (LPN)-A if sh left forearm or if R1 side when he recer The only thing we h were the skin tears elbow and he was LPN-A was asked I any report of injurie reports.	At 9:07 a.m. the consultant (CDON) with the surveyor ns. The CDON verified the g and skin tears on the a.m. the CDON reviewed m 7/1/15 and verified there was related to R10's skin issues. was expected the NAs would inges to the charge nurse. DON asked a licensed practical is noticed the bruising on the 0 had been found on his left ntly fell. LPN-A replied, "No. had noticed was after the fall on the right arm and by the found on his right side." When by CDON if she had received as LPN-A denied receipt of any	F 282	DNS or designee. The results of audits will be presented to the Qu Committee for further recommen Date of completion is 9/07/15.	ality	
F 309 SS=D	a.m. R10 had expension had expension had explained that report any changes it had been reported bruising had been ported bruising had br	(NA)-A then reported at 9:40 rienced a fall recently, which d the bruises and skin tears. tt the NAs were supposed to s in skin conditions, but thought d and investigated, as the present on R10's arm since CARE/SERVICES FOR EING t receive and the facility must ary care and services to attain hest practicable physical,	F 309			9/7/15

Facility ID: 00961

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		AND HUMAN SERVICES			F	ORM A	08/25/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3		SURVEY
		245314	B. WING			07/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP			06 HIGH STREET /INTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 309	accordance with the and plan of care. This REQUIREMED by: Based on observa review, the facility f related skin condition	his REQUIREMENT is not met as evidenced			F309 Resident #10 had an assessment and care plan review/upo related to bruising on 8-21-15. All residents will have a skin UDA, rec		
	skin tears to the rig the left forearm on following day at 7:2 tears to right forear forearm. At 9:07 a. nursing (CDON) wi R10's arms. The C bruising and skin te R10's care plan dat resident was presc thinning medication bruising). Interventi bruising. R10's 6/2/ Set (MDS) indicate impaired cognition. though 7/29/15, rev related to alteration On 7/29/15, at 9:14 progress notes from no documentation	-			review, and ensure appropriate care planning is complete by 9-07-15. Nursing staff will be educated on the G policy and procedure for skin assessin pressure ulcer prevention, and documentation requirements by 8-27-15.For those not attending the meeting, make up education will be completed by 9-7-15. Audits on weekly Documentation of sk assessments will be completed 3x per week x 4 weeks, then monthly x3 by th DNS or designee. The results of thes audits will be presented to the Quality Committee for further recommendation Date of completion is 9/07/15.	nent, kin er :he se	

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		AND HUMAN SERVICES				FORM	08/25/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245314	B. WING _			07/;	30/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP			06 HIGH STREET /INTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 6	F 30	09			
	nurse (LPN)-A if shileft forearm or if R1 side when he recent The only thing we have the skin tears elbow and he was f LPN-A was asked to any report of injurier reports. A nursing assistant a.m. R10 had expe she thought caused NA-A explained that report any changes it had been reported bruising had been ported bruising had bruising had bruising had bruising had bruising had bruising had bruisi	DON asked a licensed practical e noticed the bruising on the 10 had been found on his left ntly fell. LPN-A replied, "No. had noticed was after the fall on the right arm and by the found on his right side." When by CDON if she had received as LPN-A denied receipt of any (NA)-A then reported at 9:40 rienced a fall recently, which d the bruises and skin tears. It the NAs were supposed to a in skin conditions, but thought d and investigated, as the present on R10's arm since was brought to the staffs' nt report dated 7/29/15, noted pruise on R10's left forearm 0 centimeters (cm). sment, Pressure Ulcer cumentation Requirements sment and Documentation of s/Skin tears/Abrasions read: "If , abrasion or skin tear is dent, this should be reported to telyThe bruise/contusion/skin ld be monitored weekly and r progress toward healing nted on the Skin Observation onym] and on the resident's					

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			FC OMB	ORM / NO.	08/25/2015 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3		E SURVEY PLETED
		245314	B. WING			07/3	80/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP			06 HIGH STREET /INTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 328	Continued From pa	ge 7	F 3	28			
F 328 SS=D			F 3	28			9/7/15
	proper treatment ar special services: Injections; Parenteral and enter Colostomy, uretero Tracheostomy care Tracheal suctioning Respiratory care; Foot care; and Prostheses.	stomy, or ileostomy care; ; ;					
	by: Based on observat review, the facility f positive airway pres machine providing a and mask were clea who utilized a CPAF Findings include: R5's room was obs a.m. A C-PAP mach attached to the nos bedside adjacent to creamy white/brown mask and around th On 7/29/15, at 8:20 continued to have a on the inside and th	erved on 7/28/15, at 10:08 hine and the long tubing e piece was stored on top of a b R5's bed. The mask had a h build up in the inside of the he seams. a.m. C-PAP nasal piece mask a thick creamy/brown build up			F328 Resident #5 CPAP machine equipment has been cleaned. All residents that are on CPAP have all had their CPAP items cleaned. The manufacturer ¿s direction for cleaning been added to the TAR to ensure they cleaned daily / weekly per the recommendations. Care plans have b reviewed and updated as needed. Licensed staff will be educated about following the manufactures recommendations on all residents with CPAP by 8-27-15. For those not atten the meeting, make up education will b completed by 9-7-15. CPAP cleanliness audits will be compl weekly x 4 weeks, then monthly x3 by DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendation Date of completion 9/07/15	has r are been Iding e eted the e	

Facility ID: 00961

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	IPLETED	
		245314	B. WING		07/	30/2015	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 328	to obstructive sleep psychopharmacolo antidepressant med 4/10/14, directed st encouragement teo applying the C-PAP addition, direction v the C-PAP weekly. A 7/29/15, Admissid diagnoses including (complete or partial during sleep), insor stay asleep and native wake cycles). A nursing assistant at 9:19 a.m. that the machine involved, ' leave to dry." NA-C policy regarding clea At 9:27 a.m. the co (CDON) then verifie mask and acknowle at 10:15 a.m. the C have a policy for CI the manufacturer's A 9/12 C-PAP Ther "Please refer to the The manufacturer F instructions indicate	 night one time a day related o apnea." A gical medication and dication care plan dated aff to provide sleep shniques which included machine mask at bedtime. In vas provided to staff to clean on Record revealed R5 had g obstructive sleep apnea l blockage of upper airway nnia (inability to fall asleep or rcolepsy (poor control of sleep (NA)-C explained on 7/29/15, e cleaning of R5's C-PAP 'General carerinse out and was unsure of the facility eaning of C-PAP machines. nsultant director of nursing ed debris in R15's C-PAP edged it was not clean. Later, DON reported, "I doubt we PAP cleaning. It says to follow instructions." apy policy directed staff to manufacturer's instructions." Phillips Respironics 2014 ed masks should have been 	F 328	3			
F 334 SS=D	warm soapy water.	eadgear at least weekly in	F 334	4		9/7/15	

		AND HUMAN SERVICES				FORM	: 08/25/2015 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245314	B. WING			07/	30/2015
NAME OF I	PROVIDER OR SUPPLIER		· [S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- WINTHROP			06 HIGH STREET VINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 334	Continued From pa	ige 9	F 3	34			
	that ensure that (i) Before offering the each resident, or the representative receives benefits and potent immunization; (ii) Each resident is immunization October annually, unless the contraindicated or the immunized during the contraindicated or the immunization; and (iv) The resident or representative has immunization; and (iv) The resident's representative was the benefits and point following: (A) That the resider representative was the benefits and point for the resident's representative was the benefits and point following: (B) That the resider representative was the benefits and point for the resider representative was the benefits and point following of the the resider of the facility must determine that (i) Before offering the representative that ensure that (i) Before offering the the benefits and point for the resider the the resider the benefits and point for the benefits and po	REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 The facility must develop policies and procedures that ensure that (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		C PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY LETED	
		245314	B. WING	~	07/0/	0/0015	
NAME OF I	PROVIDER OR SUPPLIER	240014		STREET ADDRESS, CITY, STATE, ZIP CODE	07/3	0/2015	
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 334	already been immu (iii) The resident or representative has immunization; and (iv) The resident's in documentation that following: (A) That the reside representative was the benefits and por pneumococcal imm (B) That the reside pneumococcal imm the pneumococcal imm the pneumococcal imm the pneumococcal imm the pneumococcal imm years following the immunization, unle	inized; the resident's legal the opportunity to refuse medical record includes t indicated, at a minimum, the ent or resident's legal provided education regarding otential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F 33	4			
	by: Based on interview facility failed to ens offered and/or rece vaccinations as rec Disease Control (C Findings include: R41's undated Adm	NT is not met as evidenced v and document review, the ure 1 of 5 residents (R41) was evided pneumococcal commended by Centers for EDC).		F 334 The pneumococcal vaccin Resident # 41 was reviewed with t MD/NP and the recommendation i the vaccine is not indicated for a 3 old female with no respiratory histor resident was informed and in agre A review of all the resident charts i completed to ensure the proper pneumococcal vaccinations were of by 8-28-15. New admission charts	he s that 6 year ory. The ement. s offered		

Facility ID: 00961

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	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION	0MB NO. 0938-039 (X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		3		PLETED
		245314	B. WING		07/3	30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 334 F 428 SS=D	documentation if a had been received, On 7/29/15, at 3:53 additional informati administrator stated wasn't offered or gi don't know what wa I can't find risks or Review of the Good Immunizations for I indicated that upon and/or legal repres Vaccination Informa and pneumococcal potential side effec discussed with the indicated "if the res pneumococcal vac determine if it has I vaccination. Pneum indicated for those years or longer sind 483.60(c) DRUG R IRREGULAR, ACT	imunization record lacked pneumococcal vaccination contraindicated or refused. B p.m. when asked for on for R41's immunization the d "from what I understand it ven because of her age. I as said to her back in October. benefits yet." d Samaritan Society Residents policy dated 2/15, admission, each resident entative will receive the ation Statements for influenza vaccines and the benefits and ts of vaccinations will be resident. The policy further ident received a cination before age 65, been five years since that nococcal vaccination is residents if it has been five ce primary vaccination."	F 334	Licensed staff will be educated to they are offering the proper vacci admission by 8-27-15. For those attending the meeting, make up e will be completed by 9-7-15. Pneumococcal audits will be com weekly for new admits x 4 weeks monthly x3 by the DNS or designer results of these audits will be prese the Quality Committee for further recommendations. Date of completion 9/07/15.	nes upon not ducation pleted then ee. The	9/7/15
	the attending physi	ust report any irregularities to cian, and the director of reports must be acted upon.				

Facility ID: 00961

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/25/2015 APPROVED 0938-0391			
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED			
		245314	B. WING _		07/30/2015				
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-				
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 55396					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE			
F 428	Continued From pa	ge 12	F 42	8					
	by: Based on observat review, the facility f medication reviews residents (R30) rev medications. Findings include: On 7/29/15, at 9:30 sleeping in his room stated R30 always when they get him R30 was admitted t diagnoses including dementia, and majo Care plan dated 7/3 an antidepressant r alteration in mood r depressive disorder affect, not talking to A review of the con record of drug regir were not completed 2014, January 2015 July 2015. The Physician Orde R30 received Celes milligram (mg) once The Care Area Asse	o the facility on 1/9/14, with g cerebrovascular disease, or depressive disorder. B1/14, indicated R30 received elated to potential for elated to diagnosis of r evidenced by periods of flat o others. sultant pharmacist monthly nen review indicated reports I for October 2014, December 5, April 2015, June 2015, and ers dated 7/6/15, indicated ta (anti-depressant) 20		F428 Resident #30 did receiv monthly pharmacy consult rega medication regime for unnecess which was documented in the p notes of the chart. Any recomm were printed by the consultant p and forwarded to the DNS for for On 8-21-15 All residents in the f receive a pharmacy review by th consultant pharmacist for unner drugs. The consulting pharmacist /DNS further discussion noted there a completed each month and the documentation is in the progress the chart. The consultant phar aware of the regulation and kno residents need monthly docume regarding their monthly review. DNS/MDS nurse have been edu the consultant pharmacist on he procedure for documentation. Medication review audits will be completed monthly by the consu- pharmacist/DON for compliance regulation x 4 months. The res audits will be reported to the Qu Committee for further recomme Date of Completion 9/07/15.	rding his sary drugs rogress bendations bharmacist blow-up. facility will re cessary S upon the reviews s notes of macist is ws that all entation The ucated by er ulting e to this ults of the iality				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY	
		245314	B. WING		07	00/0045	
NAME OF F	PROVIDER OR SUPPLIER	240314		TREET ADDRESS, CITY, STATE, ZIP CODE	07/	30/2015	
GOOD S	AMARITAN SOCIETY	- WINTHROP		06 HIGH STREET WINTHROP, MN 55396			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 428	Continued From page 13 medication with treatable medical condition such as cerebrovascular accident and had disturbances of balance, gait, positioning ability.		F 428				
	(CP) stated she wo medication reviews	a.m. consultant pharmacist uld look for monthly and call or fax the y medication reviews were not					
	of nursing (CDON)	0 a.m. the consultant director stated if monthly medication leted, the facility would have					
F 465 SS=D	September 2012, ir center and consulta for identifying order and assist in detern medications." 483.70(h)	nedications policy dated ndicated:"pharmacy, the ant pharmacist are responsible 's from multiple prescriber's nining the use of unnecessary AL/SANITARY/COMFORTABL	F 465			9/7/15	
		ovide a safe, functional, ortable environment for the public.					
	by: Based on observat review, the facility f sanitary environme the potential to affe	NT is not met as evidenced tion, interview and document ailed to ensure a clean and nt was maintained, which had ct 3 of 28 residents (R14, R5, resident rooms observed		F465 Resident #4, 5, and 14 h their living environment inspected cleaned as appropriate. All residents have the potential to affected by this same deficient pu All resident rooms were inspecte	d and be ractice.		

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If continuation sheet Page 14 of 16

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
				G			
		245314	B. WING			30/2015	
	PROVIDER OR SUPPLIER	- WINTHROP		STREET ADDRESS, CITY, STATE, Z 506 HIGH STREET	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	WINTHROP, MN 55396 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLETIO DATE	
ma		······································		DEFICIENC			
F 465	Continued From pa	age 14	F 46				
	Findings include:			ensure a clean and sanit by 8-28-15. Nursing, housekeeping, a			
	During an environn	nental tour on 7/29/15, at 1:31		environmental service st			
		onmental services supervisor		educated on the GSS Po			
	(ESS), the following were noted and ver	g environmental concerns rified:		procedure for a clean ar environment and a clean be implemented by 8-28-	ing schedule will		
	On 7/28/15, R14's	toilet seat, behind risers, was		not attending the meeting			
		ined and an odor was		education will be comple			
		e tour ESS verified the stain		Environmental audits will			
		eaning. ESS stated staff would tain did not come off, the toilet		weekly x 4 weeks, then r DNS/ESS or designee.			
	seat would be repla			these audits will be prese Quality Committee for fu	ented to the		
	a strong odor in the	athroom was observed to have shared bathroom. During the that R5's roommate (R4)		recommendations. Date of completion 9/07/			
	used a lot of toilet p garbage for the toil	paper and used the bathroom et paper, instead of the toilet.					
		at R5 throws the incontinent and if staff doesn't empty the					
	garbage, the bathro						
		lentified that the maintenance					
		at the nurse's station, was for					
		nmental concerns. ESS also schedule for cleaning all					
	rooms and toilets w						
		3 a.m. when interviewed, NA)-B stated if she had an					
	environmental con	cern, she would notify					
		rices. If unavailable, she would					
		urse. If neither were available, concern on the maintenance					
		a.m., when interviewed, the					
	licensed practical n	urse (LPN)-B stated if she had					
	an environmental c	oncern she would write it on				1	

If continuation sheet Page 15 of 16

		AND HUMAN SERVICES				FORM	: 08/25/2015 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245314	B. WING			07/	30/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- WINTHROP		-	06 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	The facility cleaning dated December 20 "3. All parts of the neat and free of litte as necessary to kee free of accumulatio	necessary, would call them. g of common areas policy 008, revised 6/14, indicated: e community will be kept clean, er. 7. Clean surfaces as often ep furniture and equipment ns of dust, dirt, food particles, proom wastebaskets daily or as	F	465			

Facility ID: 00961

If continuation sheet Page 16 of 16

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				+5314023 FORM APPROVE ОМВ NO. 0938-039					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED			
		245314	B, WING	·		07/	28/2015			
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
GOOD S	AMARITAN SOCIETY	- WINTHROP		1	506 HIGH STREET WINTHROP, MN 55396					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	'IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
K 000	INITIAL COMMENT	ſS	к	000						
	FIRE SAFETY									
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.								
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.	×							
	Minnesota Departm Fire Marshal Divisio time of this survey, Samaritan Society V in substantial comp for participation in M Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety, State on, on July 28th, 2015. At the Building 01 of Good Winthrop was found not to be liance with the requirements Addicare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety ter 19 Existing Health Care			EPOC					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K- Health Care Fire Ins State Fire Marshal 445 Minnesota Stre	R THE FIRE SAFETY TAGS) TO: spections Division								
	St. Paul, MN 55101	-5145, or								
	y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 08/22/2015			

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.

PRINTED: 08/27/2015

		AND HUMAN SERVICES				FORM	08/27/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245314	B. WING			07/2	28/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- WINTHROP		-	INTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	кc	000			
	By eMail to: Marian.Whitney@s	tate.mn.us					
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.			κ.		
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency.					
	is a one-story build original building wa building additions c 1995. All buildings	d Samaritan Society Winthrop ing with partial basement. The s constructed 1965, with onstructed in 1966, 1994 and are fully fire sprinkler determined to be of Type					5 B
	detection in the cor corridors, which is r department notifica	re alarm system with smoke ridors and spaces open to the monitored for automatic fire tion. The facility has a and had a census of 28 at					
K 018	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	КC	018			9/7/15
SS=F		prridor openings in other than s of vertical openings, exits, or					

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Event ID: 2CND21

Facility ID: 00961

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/27/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245314	B. WING		07/2	28/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- WINTHROP		606 HIGH STREET NINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 018	those constructed of wood, or capable of minutes. Doors in s required to resist th no impediment to th are provided with a the door closed. Do are permitted.	e substantial doors, such as of 1% inch solid-bonded core resisting fire for at least 20 sprinklered buildings are only e passage of smoke. There is ne closing of the doors. Doors means suitable for keeping utch doors meeting 19.3.6.3.6 .3.6.3 rohibited by CMS regulations	K 018			٩
	Based on observat had a corridor door requirements of NF 19.3.6.3.6. This def safety of 15 of 28 re smoke were allowe corridors making it Findings include: On facility tour betw on 07/28/2015, it wa door for resident roo	reen 10:00 AM and 2:00 PM as observed that the corridor oms 109 and 111 did not fit e and would not positively		K018- The doors for room 109 and will be fixed by the facility to fit tigh the frame and positively latch. The ENS supervisor or designee w monitor for compliance Date of completion 09/07/2015	tly into	

Facility ID: 00961

If continuation sheet Page 3 of 10

		(X2) Multif A. Building	NO. 0938-039 DATE SURVEY COMPLETED		
		245314	B. WING	07	/28/2015
	PROVIDER OR SUPPLIER	- WINTHROP		STREET ADDRESS, CITY, STATE, ZIP CODE 506 HIGH STREET WINTHROP, MN 55396	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 018 K 027 SS=F	Continued From page 3 This deficient practice was verified by the Director of Environmental Services (SS). NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 ³ / ₄ -inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7		К 018 К 027		10/3/15
Based on obse provide proper p smoke barrier d accordance with (2000 edition) s Fire Doors and deficient practic patients, staff, a migrate betwee corridor untenal Findings include On facility tour b on 07/28/2015, 1. Fire doors no		s not met as evidenced by: tions, the facility has failed to ection for several corridor s throughout the facility in FPA Life Safety Code 101 on 19.3.6.3.1., and NFPA 80 e Windows (99) The following ould negatively affect the visitors as smoke could moke barriers making the ween 10;00 AM and 2:00 PM servation revealed: administration would close ould not be verified that they	•	K027- The fire doors near the administration are in the process of being replaced with verified fire doors. The fire doors near room 127 are in the process of being fixed to close tightly when tested. We are asking for an extension of 6 weeks from today to purchase and installation of the appropriate fire doors. The ENS supervisor will monitor for compliance. Date of Completion 10/03/2015	

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Facility ID: 00961

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PRINTED: 08/27/2015

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •	LE CONSTRUCTION		0938-039 SURVEY PLETED
ND PLAN OF CORRECTION		A, BUILDING 01 - MAIN BUILDING 01				
		245314	B. WING		07/	28/2015
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOOD S	AMARITAN SOCIETY	- WINTHROP	1	506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
K 027	Continued From pa	ige 4	K 027			
	2. Fire doors near when tested.	room 127 would not close				
K 050	of Environmental S	ice was verified by the Director ervices (SS). FETY CODE STANDARD	K 050			9/7/15
SS=F	varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted between	at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is impetent persons who are e leadership. Where drills are of 9 PM and 6 AM a coded by be used instead of audible				
	Based on observat facility failed to ass once per shift per of varying times and of	s not met as evidenced by: tion and staff interview, the ure fire drills were conducted juarter for all staff under conditions as required by 2000 19.7.1.2. This deficient of all 28 residents.		K50- The facility has ensured tha drills are being done monthly with the shift and times each month. The ENS supervisor/designee wi for compliance. Date of completion 09/07/2015	n rotating	
	Findings include:			2		
	07/28/2015, the rev	veen 10:00 AM and 2:00PM on view of the fire drills reports for he following drill was missed:				
	1. 4th quarter Night	abift				

		(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED		
		245314	B. WING		07/28/2015
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINTHROP	1	506 HIGH STREET WINTHROP, MN 55396	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE
K 050	Continued From pa	ige 5	K 050)	
K 054 SS=F	of Environmental S NFPA 101 LIFE SA	FETY CODE STANDARD	K 054	4	9/7/15
	activating door hold maintained, inspect	detectors, including those l-open devices, are approved, ted and tested in accordance rer's specifications. 9.6.1.3			
	Based on interview documentation, the required sensitivity on the fire alarm sy 72 National Fire Ala	s not met as evidenced by: v and review of available facility has not conducted that testing of the smoke detectors stem in accordance with NFPA arm Code (99), Sec. 7-3.2.1. ice could affect all 28 and staff.		K054- The facility will have the comparesponsible for our fire system conduct the annual sensitivity testing for the facility. The sensitivity test will be completed by 09/07/2015 The ENS supervisor/ designee will monitor for compliance	
	Findings include:			Date of Completion 09/07/2015	
	on 07/28/2015, a re fire alarm maintena documentation reve inspection the facili current documentat the required sensiti	veen 10:00 AM and 2:00 PM eview of the facility's available ince and testing ealed that at the time of the ty could not provide any tion verifying the completion of vity testing of each smoke roughout the facility.			
K 056 SS=F	of Environmental S	ice was verified by the Director ervices (SS). FETY CODE STANDARD	K 056	5	9/7/15

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PRINTED: 08/27/2015 FORM APPROVED

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DAT	0938-039
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01 - MAIN BUILDING 01	COMPLETED	
		245314	B. WING		07/28/2015	
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- WINTHROP	-	506 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 056	for the Installation of provide complete co- building. The syste accordance with NF Inspection, Testing, Water-Based Fire F supervised. There supply for the syste systems are equipp	nce with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the m is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water m. Required sprinkler bed with water flow and tamper e electrically connected to the	K 056			
	Based on observat system is not install accordance with NF Installation of Sprin to maintain the sprin with NFPA 13 (99) of out of service causi protection system of emergency that wor and staff of the faci Findings include: On facility tour betw	s not met as evidenced by: tions, the automatic sprinkler led and maintained in FPA 13 the Standard for the kler Systems (99). The failure nkler system in compliance could allow system being place ng a decrease in the fire trapability in the event of an uld affect all residents, visitors lity.		K056- The facility will have the cor who installed the sprinkler heads c and/or replace the corroded and pa sprinkler heads in the kitchen and o room. The facility will have the sam company who installed the sprinkle heads remove one of the two sprin heads that are only 1 ¿ feet apart in family lounge. The ENS supervisor will monitor fo compliance Date of completion 09/07/2015	lean ainted dining le r hkler hkler h the	
	facility's fire sprinkle	ded/painted sprinkler heads in				

		& MEDICAID SERVICES			O. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED	
		245314	B. WING		07/28/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP	1	06 HIGH STREET WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 056	Continued From pa heads 1 1/2 feet ap	-	K 056	,		
K 062 SS=F	of Environmental S NFPA 101 LIFE SA Required automatic continuously mainta condition and are ir	ice was verified by the Director ervices (SS). FETY CODE STANDARD c sprinkler systems are ained in reliable operating hspected and tested .6, 4.6.12, NFPA 13, NFPA 25,	K 062	₩E	9/7/15	
	Based on documer with staff, the facilit and maintain the au accordance with NF Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire F deficient practice do sprinkler system is fully operational in t	s not met as evidenced by: ntation review and interview y has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), I 4.6.12, NFPA 13 Installation is (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This pes not ensure that the fire functioning properly and is the event of a fire and could ect all residents, staff and		K062- The facility has completed the annual sprinkler test on 01/29/2015 The ENS supervisor/designee will monit for compliance Date of compliance 09/07/2015	or	
	on 07/28/2015, a re interview with the D Services (SS), reve complete their annu	veen 10:00 AM and 2:00 PM eview of documentation and Director of Environmental ealed the facility failed to ual fire sprinkler test as 13(99) and NFPA 25(98). The		(1		

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION (X	3) DATE SURVE		
	OF CORRECTION	IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01	COMPLETED 07/28/2015		
		245314	B. WING				
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - WINTHROP				506 HIGH STREET WINTHROP, MN 55396			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ETIC	
K 062	previous sprinkler to September 12th, 20 annual test/inspecti 29th, 2015 resulting	-	K 062				
K 067 SS=F	of Environmental Son NFPA 101 LIFE SA Heating, ventilating with the provisions in accordance with	FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed	K 067		9/7/15	5	
	Based on observat could not be verified ventilating and air c was maintained in a (2000) Chapter 19, 9, Section 9.1 and 1 emergency, a nonc	s not met as evidenced by: ion and a staff interview, it d whether the facility's general onditioning system (HVAC) accordance with NFPA 101 Section 19.5.2.1 and Chapter NFPA 90A [1999]. In a fire ompliant HVAC system could residents, staff and visitors.		K067- The facility will have the HVA0 system that contains fire/smoke dam to be inspected and tested by the company that maintains our fire/smol dampers. The ENS supervisor will monitor for compliance. Date of completion 09/07/2015	pers		
	On 07/28/2015 at 1 with facility staff, it v system does contai dampers, however, provided verifying t	0:00AM, during an interview was confirmed the HVAC n one or more fire/smoke no documentation could be the fire/smoke dampers were ed within the previous 4 years,					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY		
		245314	B. WING	0	07/28/2015		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 506 HIGH STREET WINTHROP, MN 55396				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
K 067	Section 3-4.7. This deficient pract	NFPA 90A [1999] Chapter 3, ice was verified by the Director	K 067				
K 069 SS=F		FETY CODE STANDARD	K 069		9/7/15		
	Based on a review interview with staff, kitchen hood suppr accordance with NI (edition 2000), Sec Standard for Ventila Protection of Comr (edition 1998) secti practice could nega	s not met as evidenced by: of documentation and an it was determined that the ression system is not in FPA 101 The Life Safety Code tion 19.3.2.6 and NFPA 96 ation Control and Fire nercial Cooking Operation on 1-3.1. This deficient atively affect any residents, any ff in the kitchen area.		K069- The facility had the maintenance the hood suppression system completed on 03/16/2015 The ENS supervisor will monitor for compliance Date of completion 09/07/2015	of		
	on 07/28/2015, obs maintenance on the was last completed	our at approximately 10:00 AM, servations revealed that the e hood suppression system l in September 16, 2014. ice was verified by the Director ervices (SS)	*				

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Facility ID: 00961

If continuation sheet Page 10 of 10

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0		FE SURVEY MPLETED	
		245314	B. WING	B. WING		
	PROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 66 HIGH STREET		
GOOD S/	AMARITAN SOCIETY	- WINTHROP	w	INTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 000			
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.			ж.	
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Division time of this survey, Samaritan Society substantial complian participation in Med Subpart 483.70(a), 2000 edition of Nate Association (NFPA)	Survey was conducted by the nent of Public Safety, State on, on July 28, 2015. At the Building 02 of Good Winthrop was found not in once with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety oter 18 New Health Care		EPOC		
	DEFICIENCIES (K	R THE FIRE SAFETY -TAGS) TO:				
	Health Care Fire In State Fire Marshal 445 Minnesota Stre St. Paul, MN 55107	Division eet, Suite 145				

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/27/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - 2006 ADDITION				E SURVEY PLETED
		245314	B. WING			07/28/2015	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 506 HIGH STREET		
GOOD S	AMARITAN SOCIETY	- WINTHROP			WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000	By eMail to: Marian.Whitney@s THE PLAN OF CO	-	K	000			
	FOLLOWING INFO 1. A description of v to correct the defici	DRMATION: what has been, or will be, done ency.	2.				
	3. The name and/o responsible for corr	oposed, completion date. r title of the person rection and monitoring to ence of the deficiency.					
	consists of a six-be constructed in 2006 height, has no base	d Samaritan Society Winthrop d resident room addition, 5. Building 02 is one-story in ement, is fully fire sprinkler determined to be of Type			*		
	detection in the cor corridors, which is r department notifica Building 02 are equ detection. The faci	re alarm system with smoke ridors and spaces open to the monitored for automatic fire tion. All resident rooms in hipped with automatic smoke lity has a capacity of 37 beds of 28 at time of the survey.					
K 018 SS=F	NOT MET as evide NFPA 101 LIFE SA Doors protecting co constructed to resis	42 CFR, Subpart 483.70(a) is inced by: FETY CODE STANDARD prridor openings are st the passage of smoke. with positive latching	к	018	3		9/7/15

Facility ID: 00961

If continuation sheet Page 2 of 8

STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 02 - 2006 ADDITION		E SURVEY PLETED
		245314	B. WING		07/28/2015	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 506 HIGH STREET WINTHROP, MN 55396			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 018		age 2 loors meeting 18.3.6.3.6 are atches are prohibited.	K 018			
	Based on observa failed to maintain of the means of egres requirements at NF Section 18.3.6.3. adversely affect 10			K018- The doors for room 133 ar will be fixed to fit tightly into the fra positively latch. The ENS supervisor or designee monitor for compliance Date of completion 09/07/2015	ame and	
	on 07/28/2015, it w door for resident ro	ween 10:00 AM and 2:00 PM ras observed that the corridor poms 133 and 134 did not fit re and would not positively				
K 029 SS=F	of Environmental S NFPA 101 LIFE SA	FETY CODE STANDARD	K 029			9/7/15
-	with 8.4. The area fire-rated barrier, w without windows (in	are protected in accordance s are enclosed with a one hour with a 3/4 hour fire-rated door, n accordance with 8.4). Doors automatic closing in 2.1.8. 18.3.2.1		-		
	This STANDARD	is not met as evidenced by:				

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		& MEDICAID SERVICES				0938-039 E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 02 - 2006 ADDITION		
		245314	B, WING	07/:	07/28/2015	
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AMARITAN SOCIETY	WINTHROD		506 HIGH STREET		
000 3	AWARITAN SUCIET			WINTHROP, MN 55396		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
K 029	Continued From pa		K 029		•	
11 020	Based on observation maintain a hazardo with NFPA 101 (00) and 19.3.6.3.2, and 8.2.3.2.3.2. In a first	tion, the facility failed to us area door in accordance o, Chapter 19, Section 19.3.2.1 I Chapter 8, Section e emergency, this deficient ersely affect 10 of 28	N 023	K029- The hoyer lifts and the soil bins have been removed from be shop. The staff will all be educated what things can be stored in the be shop. The ENS supervisor/designee will for compliance	auty d on beauty	
	FINDINGS INCLUE	DE:		Date of completion 09/07/2015		
	PM on 07/28/2015, Beauty Shop had e could consider it to The items in this ro	between 10:00 AM and 2:00 observation revealed that the xcessive storage in it that be a hazardous storage room, om included hoyer lifts, soiled door is not equipped with a				
	of Environmental S	ice was verified by the Director ervices (SS). FETY CODE STANDARD	K 050			9/7/15
	varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercise conducted between	at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. lanning and conducting drills is impetent persons who are the leadership. Where drills are the 9 PM and 6 AM a coded by be used instead of audible		8		
		s not met as evidenced by: s not met as evidenced by:		K50- The facility has ensured that drills are being done monthly with		

- STATE OF STATE

Facility ID: 00961

If continuation sheet Page 4 of 8

Contraction of the local distance of the		& MEDICAID SERVICES		LE CONSTRUCTION	VB NO, 0938-039 (X3) DATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT!FICATION NUMBER:	1	6 02 - 2006 ADDITION	COMPLETED
		245314	B. WING		07/28/2015
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD SAMARITAN SOCIETY - WINTHROP				506 HIGH STREET	
0000 0				WINTHROP, MN 55396	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTIO
K 050		-	K 050) the shift and times each month.	
	Based on observation and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required in the			The ENS supervisor/designee will a for compliance.	nonitor
	last 12-month period affect how staff read	od. This deficient practice could ct in the event of a fire. by staff would affect the safety		Date of completion 09/07/2015	
	Findings include:				
	07/28/2015, the rev	veen 10:00 AM and 2:00PM on view of the fire drills reports for he following drill was missed:			
	1. 4th quarter Night	t shift.			
K 054	of Environmental S	ice was verified by the Director ervices (SS). FETY CODE STANDARD	K 054	L	9/7/15
SS=F	activating door hold maintained, inspec	detectors, including those l-open devices, are approved, ted and tested in accordance rer's specifications. 9.6.1.3			
	This STANDARD i This STANDARD i Based on interview documentation, the required sensitivity on the fire alarm sy	s not met as evidenced by: s not met as evidenced by: and review of available facility has not conducted that testing of the smoke detectors stem in accordance with NFPA arm Code (99), The deficient		K054- The facility will have the cor responsible for our fire system cor the annual sensitivity testing for the facility. The sensitivity test will be completed by 09/07/2015 The ENS supervisor/ designee will monitor for compliance Date of Completion 09/07/2015	duct

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Facility ID: 00961

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			5 UZ - 2006 ADDITION		
	245314			07/2	28/2015
PROVIDER OR SUPPLIER					
AMARITAN SOCIETY	- WINTHROP				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETIO DATE
Continued From pa Findings include:	ge 5	K 054	8		
on 07/28/2015, a re fire alarm maintena documentation reve inspection the facili current documentat the required sensiti	eview of the facility's available nce and testing ealed that at the time of the ty could not provide any ion verifying the completion of vity testing of each smoke				
of Environmental S NFPA 101 LIFE SA Required automatic continuously mainta condition and are in	ervices (SS). FETY CODE STANDARD sprinkler systems are ained in reliable operating spected and tested			-	9/7/15
Based on documer with staff, the facility and maintain the au accordance with NF section 18.7.6, 4.6. does not ensure tha functioning properly event of a fire and o	tation review and interview y has failed to properly inspect tomatic sprinkler system in PA 101 Life Safety Code (00) 12. This deficient practice at the fire sprinkler system is y and is fully operational in the could negatively affect all		annual sprinkler test on 01/29/2015		
Findings include:					
	PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa Findings include: On facility tour betw on 07/28/2015, a re fire alarm maintena documentation reve inspection the facilit current documentat the required sensitiv detector located thr This deficient praction of Environmental Se NFPA 101 LIFE SA Required automatic continuously maintat condition and are im periodically. 18.7.6 9.7.5 This STANDARD is Based on document with staff, the facility and maintain the automatic accordance with NF section 18.7.6, 4.6.1 does not ensure that functioning properly event of a fire and or residents, staff and	245314 PROVIDER OR SUPPLIER AMARITAN SOCIETY - WINTHROP SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Findings include: On facility tour between 10:00 AM and 2:00 PM on 07/28/2015, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient practice was verified by the Director of Environmental Services (SS). NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00) section 18.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all residents, staff and visitors.	A BOILDING A BOILDING 245314 BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Findings include: On facility tour between 10:00 AM and 2:00 PM on 07/28/2015, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient practice was verified by the Director of Environmental Services (SS). NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00) section 18.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning property and is fully operational in the event of a fire and could negatively affect all residents, staff and visitors.	245314 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AMARITAN SOCIETY - WINTHROP STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (REACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (REACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Findings include: No PROVIDERS PLAN OF CORRECTION (REACH DEFICIENCY MIST ADDRESS) On facility tour between 10.00 AM and 2:00 PM on 07/28/2015, a review of the facility's available fire alarm maintenance and testing documentation revealed that at the time of the inspection the facility could not provide any current documentation or provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. K 062 This deficient practice was verified by the Director of Environmental Services (SS). K 062 Required automatic sprinkler systems are continuously maintained in reliable operating periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 K 062- The facility has completed th annual sprinkler test on 01/29/2015 The ENS supervisor/designee will r for compliance Date of compliance Date of compliance 09/07/2015 Date of compliance 09/07/2015	A BUILDING U2 - 2006 ADDITION A BUILDING U2 - 2006 ADDITION A BUILDING U2 - 2006 ADDITION A BUILDING U2 - 2006 ADDITION AMARITAN SOCIETY - WINTHROP STREET ADDRESS, CITY, STATE, ZIP CODE 506 High STREET WINTHROP, MN 55396 OT/2 MARITAN SOCIETY - WINTHROP STREET ADDRESS, CITY, STATE, ZIP CODE 506 High STREET WINTHROP, MN 55396 STREET ADDRESS, CITY, STATE, ZIP CODE 506 High STREET WINTHROP, MN 55396 STREET ADDRESS, CITY, STATE, ZIP CODE 506 High STREET Continued From page 5 Findings include: PREVX FRAME CROSS-REFERENCED STRUCK (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) CROSS-REFERENCE) STREET WINTHROP, MN 55396 Continued From page 5 K 054 K 054 K 054 STREET ADDRESS, CITY, STATE, ZIP CODE STATE, STANDARD AD CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) K 054 STREET WINTHROP, MN 55396 STREET WINTHROP, MN 55396 K 054 Continued From page 5 K 054 K 054 K 054 STREET STREET K 054 STREET WINTHROP, MN 55396 K 054 STREET WINTHROP, MN 55396 K 062 STREET STREET STREET WINTHROP, MN 55396 STREET STREET STREET STREET STREET WINTHROP, MN 55396 STREET STREET STREET WINTHROP, MN 55396 STREET STREET STREET STREET STREET STREET STREET STREET STREET STREET

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Facility ID: 00961

If continuation sheet Page 6 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	02 - 2006 ADDITION	COMPLETED	
		245314	B. WING			07/28/2015	
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP	8	-	06 HIGH STREET VINTHROP, MN 55396		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062 K 067 SS=F	interview with the D Services (SS), reve complete their annu required by NFPA 1 previous sprinkler to September 12th, 20 annual test/inspecti 29th, 2015 resulting inspection and main This deficient praction of Environmental So NFPA 101 LIFE SA Heating, ventilating with the provisions in accordance with specifications. 9. 90A This STANDARD is Based on observator revealed that the fat part of the air distritor make-up air for the exhaust, throughout accordance with NF practice could allow to travel far from the affect all residents,	eview of documentation and birector of Environmental aled the facility failed to ual fire sprinkler test as 3(99) and NFPA 25(98). The esting was done on 013 and last fire sprinkler on was conducted on January g in more than a year between ntaining their system. ice was verified by the Director ervices (SS). FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed		062	K067- The facility will have the HV system that contains fire/smoke da to be inspected and tested by the company that maintains our fire/sm dampers. The ENS supervisor will monitor for compliance. Date of completion 09/07/2015	mpers noke	9/7/15

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Facility ID: 00961

If continuation sheet Page 7 of 8

		AND HUMAN SERVICES	OMB NO. 0938-0391					
		& MEDICAID SERVICES						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 02 - 2006 ADDITION	N	COM	E SURVEY IPLETED	
		245314	B. WING				28/2015	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GOOD S	AMARITAN SOCIETY	- WINTHROP		506 HIGH STREET WINTHROP, MN 🕴	55396			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORREC RECTIVE ACTION SHO RENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 067	Continued From pa On 07/28/2015 at 1 with facility staff, it v system does contai dampers, however, provided verifying inspected and teste in accordance with Section 3-4.7.	age 7 0:00AM, during an interview was confirmed the HVAC in one or more fire/smoke no documentation could be the fire/smoke dampers were ed within the previous 4 years, NFPA 90A [1999] Chapter 3, ice was verified by the Director	K 067		DEFICIENCY)			
FORM CMS-2	567(02-99) Previous Versions	B Obsolete Event ID: 2CND2	:1 Fa	acility ID: 00961	lf co	ntinuation she	et Page 8 of 8	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted August 13, 2015

Mr.. Marcus Parence, Administrator Good Samaritan Society - Winthrop 506 High Street Winthrop, MN 55396

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5314024

Dear Mr.. Parence:

The above facility was surveyed on July 27, 2015 through July 30, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

Good Samaritan Society - Winthrop August 13, 2015 Page 2

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

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

Minnesc	ota Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00961	B. WING		07/3	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP 506 HIGH WINTHROP	STREET DP, MN 5539	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff, the following correct corrections are com make a copy of the original to the Minne Division of Complia	FS: / 30th 2015, surveyors of this visited the above provider and tion orders are issued. When hpleted, please sign and date, se orders and return the esota Department of Health, nce Monitoring, Licensing and				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 08/22/15

If continuation sheet 1 of 16

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00961	B. WING		07/30/2015
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
OOD S	AMARITAN SOCIETY	- WINTHROP	H STREET OP, MN 553	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 000	Continued From pa	age 1	2 000		
	Certification Progra MN 55164-0900.	am, P.O. Box 64900 St. Paul,			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		9/7/15
		omprehensive plan of care I personnel involved in the t.			
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview and document ailed to ensure a care plan of 3 residents (R10) reviewed kin concerns.		Corrected	
	Findings included:				
	was prescribed an medication known	ted 5/24/15, directed staff R10 anticoagulant (blood thinning to contribute to bruising). led monitoring for bruising.			
	discoloration and sl discoloration on the 9:37 a.m. The follow bruises and skin te to the left forearm. director of nursing looked at R10's arm	to have several spots of skin kin tears to the right arm and e left forearm on 7/28/15, at wing day at 7:20 a.m. R10's ars to right forearm and bruise At 9:07 a.m. the consultant (CDON) with the surveyor ns. The CDON verified the g and skin tears on the			
	On 7/29/15, at 9:14	a.m. the CDON reviewed			

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00961	 B. WING		07/	30/2015
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE. ZIP CODE		50/2015
	AMARITAN SOCIETY	- WINTHBOP 506 HIGH	ISTREET			
		WINTHR	OP, MN 55396			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 565	Continued From pa	age 2	2 565			
	no documentation in The DON stated it is report any skin cha At 9:26 a.m. the CE nurse (LPN)-A if shi left forearm or if R1 side when he recent The only thing we have were the skin tears elbow and he was to LPN-A was asked by	n 7/1/15 and verified there was related to R10's skin issues. was expected the NAs would nges to the charge nurse. DON asked a licensed practica e noticed the bruising on the 0 had been found on his left ntly fell. LPN-A replied, "No. nad noticed was after the fall on the right arm and by the found on his right side." When by CDON if she had received as LPN-A denied receipt of any	ł			
	a.m. R10 had expe she thought caused NA-A explained that report any changes it had been reporte	(NA)-A then reported at 9:40 rienced a fall recently, which d the bruises and skin tears. at the NAs were supposed to a in skin conditions, but though d and investigated, as the present on R10's arm since	t			
	SUGGESTED MET	THOD OF CORRECTION:				
	(s)could review and procedures related each individual resi of nursing or design to educate staff and	sing (DON) or designee d revise policies and to ensuring the care plan for ident is followed. The director nee (s)could develop a system d develop a monitoring system providing care as directed by care.				
		R CORRECTION: Twenty-one				

	ta Department of He					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)) DATE SURVEY COMPLETED	
		00961	B. WING		07/30/2015	
	PROVIDER OR SUPPLIER		DDRESS. CITY.	STATE, ZIP CODE	01/00/2010	
	AMARITAN SOCIETY	506 HIG	STREET			
GOOD 3		WINTHR	OP, MN 5539	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 565	Continued From pa	ige 3	2 565			
	(21) days.					
2 830	MN Rule 4658.0520 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830		9/7/15	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on id preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility f related skin condition with observed bruis continuous positive breathing machine machine and mask	ent is not met as evidenced ion, interview and document ailed to identify non-pressure ons for 1 of 3 residents (R10) sing and failed to ensure the airway pressure (C-PAP providing air for sleep apnea) were cleaned for 1 of 1 utilized a CPAP machine.		Corrected		
	Findings include:					
	skin tears to the rig the left forearm on following day at 7:2 tears to right forear	oots of skin discoloration and ht arm and discoloration on 7/28/15, at 9:37 a.m. The 0 a.m. R10's bruises and skin m and bruise to the left m. the consultant director of				

	NT OF DEFICIENCIES	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00961	B. WING		07/	30/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		I STREET OP, MN 55396	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 830	nursing (CDON) wi R10's arms. The C bruising and skin te R10's care plan dat resident was presc thinning medication bruising). Interventi bruising. R10's 6/2/ Set (MDS) indicate impaired cognition. though 7/29/15, rev related to alteration On 7/29/15, at 9:14 progress notes from no documentation of The DON stated it we report any skin cha At 9:26 a.m. the CE nurse (LPN)-A if sh left forearm or if R1 side when he recent The only thing we he were the skin tears elbow and he was for LPN-A was asked to any report of injurier reports. A nursing assistant a.m. R10 had expension it had been reported	age 4 th the surveyor looked at DON verified the presence of ears on the resident's arms. ted 5/24/15, indicated the ribed an anticoagulant (blood a known to contribute to ions included monitoring for (15, quarterly Minimum Data d the resident had severely Progress Notes dated 7/1/15 vealed no documentation is in the resident's arms. A a.m. the CDON reviewed in 7/1/15 and verified there was related to R10's skin issues. was expected the NAs would inges to the charge nurse. DON asked a licensed practical is noticed the bruising on the 0 had been found on his left htly fell. LPN-A replied, "No. had noticed was after the fall on the right arm and by the found on his right side." When by CDON if she had received as LPN-A denied receipt of any (NA)-A then reported at 9:40 rrienced a fall recently, which d the bruises and skin tears. at the NAs were supposed to a in skin conditions, but thought d and investigated, as the present on R10's arm since				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00961			07/	30/2015
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		50/2015
GOOD S	AMARITAN SOCIETY	' • WINTHROP	H STREET OP, MN 55396			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	-	2 830			
	attention, an incide the presence of a b	vas brought to the staffs' ent report dated 7/29/15, noted pruise on R10's left forearm 0 centimeters (cm).				
	Prevention And Do policy under Asses Bruises/Contusions a bruise, contusion observed on a resi the nurse immedia	sment, Pressure Ulcer cumentation Requirements sment and Documentation of s/Skin tears/Abrasions read: "If a, abrasion or skin tear is dent, this should be reported to telyThe bruise/contusion/skir Id be monitored weekly and	0			
	any changes and/c should be docume	or progress toward healing nted on the Skin Observation onym] and on the resident's				
	a.m. A C-PAP mac attached to the nos bedside adjacent to	served on 7/28/15, at 10:08 hine and the long tubing se piece was stored on top of a p R5's bed. The mask had a n build up in the inside of the he seams.				
) a.m. C-PAP nasal piece mash a thick creamy/brown build up he seams.	ς			
	directing "C-PAP at to obstructive sleep psychopharmacolo antidepressant me 4/10/14, directed s	gical medication and dication care plan dated taff to provide sleep				
	applying the C-PAF	chniques which included 9 machine mask at bedtime. In was provided to staff to clean				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00961	B. WING		07/	30/2015
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE		00/2010
OOD S	AMARITAN SOCIETY	- WINTHROP 506 HIGH	STREET OP, MN 55396	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 6	2 830			
	diagnoses including (complete or partia during sleep), insol stay asleep and na wake cycles). A nursing assistant	on Record revealed R5 had g obstructive sleep apnea I blockage of upper airway mnia (inability to fall asleep or rcolepsy (poor control of sleep t (NA)-C explained on 7/29/15, e cleaning of R5's C-PAP				
	leave to dry." NA-C	"General carerinse out and was unsure of the facility eaning of C-PAP machines.				
	(CDON) then verifimask and acknowl at 10:15 a.m. the C	nsultant director of nursing ed debris in R15's C-PAP edged it was not clean. Later, DON reported, "I doubt we PAP cleaning. It says to follow instructions."				
	"Please refer to the The manufacturer instructions indicate	apy policy directed staff to e manufacturer's instructions." Phillips Respironics 2014 ed masks should have been headgear at least weekly in				
	The director of nurs and revise policies, monitor to assure r are appropriately m	THOD OF CORRECTION: sing or designee, could review /procedures, train staff and esidents and their equipment nonitored. The director of e could develop an audit tool to e care is provided.				
	TIME PERIOD FO (21) days. epartment of Health	R CORRECTION: Twenty-one				

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		í c	OATE SURVEY OMPLETED
00961	B. WING		07/30/2015
R STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
		6	
ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
B10 A.B.C Drug Regimen Review imen of each resident must be monthly by a pharmacist d by the Board of Pharmacy. be done in accordance with e State Operations Manual, ures for Pharmaceutical Service Long-Term Care, published by of Health and Human Services, ncing Administration, April 1992. incorporated by reference. It is the Minitex interlibrary loan subject to frequent change. macist must report any be director of nursing services g physician, and these reports oon by the time of the next sooner, if indicated by the purposes of this part, "acted acceptance or rejection of the gning or initialing by the director es and the attending physician. Inding physician does not concur ist's recommendation, or does uate justification, and the ves the resident's quality of life is affected, the pharmacist must o the medical director for review ector is not the attending medical director determines that sician does not have adequate e order and if the attending ot change the order, the matter			9/7/15
	00961 FR STREET AD TY - WINTHROP 506 HIGH WINTHROP STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) B10 A.B.C Drug Regimen Review imen of each resident must be monthly by a pharmacist d by the Board of Pharmacy. be done in accordance with e State Operations Manual, ures for Pharmaceutical Service Long-Term Care, published by of Health and Human Services, nncing Administration, April 1992. incorporated by reference. It is the Minitex interlibrary loan subject to frequent change. macist must report any be director of nursing services g physician, and these reports on by the time of the next sooner, if indicated by the purposes of this part, "acted acceptance or rejection of the gning or initialing by the director es and the attending physician. Inding physician does not concur sist's recommendation, or does uate justification, and the ves the resident's quality of life is affected, the pharmacist must o the medical director for review ector is not the attending medical director determines that vsician does not have adequate e order and if the attending ot change the order, the matter	00961 B. WING B. WING TY - WINTHROP STREET ADDRESS, CITY, S STATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ID PREFIX TAG 310 A.B.C Drug Regimen Review 21530 310 A.B.C Drug Regimen Review 21530 at the Board of Pharmacy. be done in accordance with e State Operations Manual, ures for Pharmaceutical Service Long-Term Care, published by of Health and Human Services, nncing Administration, April 1992. incorporated by reference. It is the Minitex interlibrary loan subject to frequent change. macist must report any he director of nursing services op hysician, and these reports on by the time of the next sooner, if indicated by the purposes of this part, "acted acceptance or rejection of the gring or initialing by the director es and the attending physician. nding physician does not concur- tist's recommendation, or does uate justification, and the ves the resident's quality of life is affected, the pharmacist must o the medical director for review ector is not the attending medical director determines that viscian does not have adequate e order and if the attending	00961 B. WING Green STREET ADDRESS, CITY, STATE, ZIP CODE 506 HIGH STREET WINTHROP 506 HIGH STREET WINTHROP, MN 55396 STATEMENT OF DEFICIENCIES (CMUST BE PRECEDED BY FULL ALSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 310 A.B.C Drug Regimen Review 21530 at a coordance with e State Operations Manual, ures for Pharmaceutical Service Long-Term Care, published by of Health and Human Services, nacing Administration, April 1992. incorporated by reference. It is the Minitex interlibrary loan subject to frequent change. macist must report any e director of nursing services j physician, and these reports sooner, if indicated by the purposes of this part, "acted acceptance or rejection of the pning or initialing by the director as and the attending moding physician does not concur ist's recommendation, or does uate justification, and the ves the resident's quality of life is affected, the pharmacist must o the medical director determines that sician does not have adequate e order and if the attending ot change the order, the matter

	ta Department of He		1		FORM APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00961	B. WING		07/30/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		I STREET OP, MN 5539	96	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
21530	Continued From pa	age 8	21530		
	by: Based on observat review, the facility f medication reviews	ent is not met as evidenced ion, interview and document failed to ensure monthly were completed for 1 of 5 viewed for unnecessary		Corrected	
	Findings include:				
	sleeping in his roor) a.m. R30 was observed n. Nursing assistant (NA)-C sleeps in until 10:00 a.m. up for the day.			
	diagnoses including	to the facility on 1/9/14, with g cerebrovascular disease, or depressive disorder.			
	an antidepressant alteration in mood	31/14, indicated R30 received related to potential for related to diagnosis of r evidenced by periods of flat o others.			
	record of drug regin were not completed	sultant pharmacist monthly men review indicated reports d for October 2014, December 5, April 2015, June 2015, and			
		ers dated 7/6/15, indicated xa (anti-depressant) 20 e daily.			
	7/30/15, indicated I medication with tre	essment (CAA) analysis dated R30 was on antidepressant atable medical condition such			
nesota D ATE FORI	epartment of Health VI		6899	2CND11	If continuation sheet 9 c

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00961	B. WING		07/	30/2015
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	017	50/2015
GOOD S	AMARITAN SOCIETY	- WINTHROP	H STREET OP, MN 55396	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 9	21530			
	as cerebrovascular disturbances of bal	r accident and had lance, gait, positioning ability.				
	(CP) stated she wo medication reviews) a.m. consultant pharmacist buld look for monthly and call or fax the ly medication reviews were no	t			
	of nursing (CDON)	0 a.m. the consultant director stated if monthly medication bleted, the facility would have				
	September 2012, in center and consulta for identifying order	nedications policy dated ndicated:"pharmacy, the ant pharmacist are responsible rs from multiple prescriber's mining the use of unnecessary				
	SUGGESTED MET	THOD OF CORRECTION:				
	consulting pharmac medication reviews could be educated importance of the p monitor to assure r DON or designee,	director of nursing (DON) and cist could ensure monthly were completed. Nursing stat as necessary to the oharmacist's review and reviews were completed. The along with the pharmacist, tion reviews on a regular basis ace.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00961	B. WING		07/30/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
GOOD SA	AMARITAN SOCIETY		I STREET OP, MN 5539	06	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
21670	Continued From pa	ge 10	21670		
21670	MN Rule 4658.140	5 A.B.C.D. Resident Units	21670		9/7/15
	resident: A. A bed of pro convenience of the mattress, and clear weather and reside condition. Each be bedspread. A mois mattress cover mus confined to bed and Rollaway type beds not be used. B. A chair or pl than the bed. C. A place adja personal possessio with a drawer. D. Clean bath I often as needed. E. A bed light conv	a must be provided for each per size and height for the resident, a clean, comfortable bedding, appropriate for the nt's comfort, that are in good d must have a clean sture-proof mattress or st be provided for all residents d for other beds as necessary. cots, or folding beds must ace for the resident to sit other acent or near the bed to store ons, such as a bedside table linens provided daily or more reniently located and of an e needs of the resident while cent chair			
	by: Based on observati review the facility fa sanitary bed linens of 1 resident (R5) re living. Findings included:	ent is not met as evidenced ion, interview and document ailed to ensure clean and were provided as needed for 1 eviewed for activites of daily 8 a.m. during R5's room		Corrected	
	observations the fit	ted sheet was noted to have a by the right grab bar.			

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00961	B. WING		07/	30/2015
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP	H STREET ROP, MN 55390	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21670	Continued From pa	ge 11	21670			
	wheeled to the dinit the meal, at 8:20 a. was transferred back into the recliner char fitted sheet on R5's large brown smear, On 7/29/15, at 9:22 (LPN)-B, during a s verified the brown s grab bar. LPN-B ex was not R5's bath of been changed. LPN nursing assistant of During interview, at director of nursing of brown smear on the	a.m. R5 was observed to be ng room in a wheelchair. After m., with staff assistance R5 ck to her room and assisted air. During this observation, the bed was still soiled with a , up near the bed rail. ca.m. licensed practical nurse subsequent tour to the room, smear on bedsheet near the plained that even though it day, the linen should have N-B stated she would have the nange it. cp:27 a.m., the consultant (CDON) commented that the e sheet appeared to be fecal he bed sheet should have	e			
	The Director of Nur policies/procedures monitor to assure b residents use.	THOD OF CORRECTION: sing or designee could review s, provide staff training and bed linens are clean for the				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	Ð			
21695	MN Rule 4658.141 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			9/7/15
		eping. A nursing home must ing and maintenance services				

Minnesc	ta Department of He	alth				(THOVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		00961	B. WING		07/3	0/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINTHROP	I STREET OP, MN 553	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	comfortable interior ceilings, registers, f and furnishings. This MN Requireme- by: Based on observati review, the facility f sanitary environme the potential to affe R4) who resided in during the environm Findings include: During an environm p.m., with the envir (ESS), the following were noted and ver On 7/28/15, R14's f observed to be stai detected. During th and the need for cle clean it and if the si seat would be replat On 7/28/15, R5's ba a strong odor in the tour ESS explained used a lot of toilet p garbage for the toile ESS also stated that	ain a clean, orderly, and c, including walls, floors, ixtures, equipment, lighting, ent is not met as evidenced on, interview and document ailed to ensure a clean and nt was maintained, which had ct 3 of 28 residents (R14, R5, resident rooms observed nental tour on 7/29/15, at 1:31 onmental services supervisor g environmental concerns ified: collet seat, behind risers, was ned and an odor was e tour ESS verified the stain eaning. ESS stated staff would tain did not come off, the toilet iced. athroom was observed to have e shared bathroom. During the that R5's roommate (R4) waper and used the bathroom et paper, instead of the toilet. at R5 throws the incontinent	21695	Corrected		
	garbage, the bathro On 7/29/15, ESS id clipboard, located a	and if staff doesn't empty the bom has an odor. entified that the maintenance at the nurse's station, was for				
Minnesota D STATE FORI	epartment of Health VI		6899	2CND11	If continuatior	n sheet 13 of 16

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00961		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		B. WING		07/	07/30/2015	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINTHROP	H STREET ROP, MN 55396	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21695	Continued From pa	ge 13	21695			
	staff to write environmental concerns. ESS also stated the cleaning schedule for cleaning all rooms and toilets was daily.					
	nursing assistant (N environmental cond environmental serv notify the charge nu she would write the clipboard. At 9:17 a licensed practical n an environmental c	a.m. when interviewed, NA)-B stated if she had an cern, she would notify ices. If unavailable, she would urse. If neither were available, concern on the maintenance u.m., when interviewed, the urse (LPN)-B stated if she had oncern she would write it on ecessary, would call them.				
	dated December 20 "3. All parts of the neat and free of little as necessary to kee free of accumulatio	g of common areas policy 008, revised 6/14, indicated: e community will be kept clear er. 7. Clean surfaces as often ep furniture and equipment ns of dust, dirt, food particles, proom wastebaskets daily or a us needed."				
	The director of nurs housekeeping or de bathroom toilets are that bathrooms are procedures could b	THOD OF CORRECTION: sing, maintanence, esignee could assure that e in working order, clean and odor free. Policy and e reviewed and staff trained to departments are notified.	o			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	•			
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			9/7/15

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00961	B. WING		07/30/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	• WINTHROP	I STREET OP, MN 553	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21810	Continued From pa	age 14	21810			
	medical and person needs. Appropriate care designed to en highest level of phy This right is limited	e the right to appropriate nal care based on individual e care for residents means nable residents to achieve thei rsical and mental functioning. where the service is not blic or private resources.	r			
	by: Based on observati review, the facility f within reach for 1 o	ent is not met as evidenced ion, interview and document ailed to ensure a call light was f 1 resident (R46) whose call ch during a specialized		Corrected		
	Findings include:					
	awake sitting up in pumps on both legs hanging on R46's g should the resident staff. A licensed pra the room and the re pointed out to the L not within reach" ar armrest. LPN-A sta been within the res	a.m., R46 was observed to be his recliner, with arterial s. The call light cord was grab bar and not within reach thave needed assistance from actical nurse (LPN)-A entered esident's call light position was .PN. LPN-A stated, "No, it is nd moved it to the recliner ted the call light should have ident's reach, and R46 stated h and use the call light.				
	indicated R46 had in The corresponding analysis dated 6/14 assistance with act including bed mobil	inimum Data Set dated 6/9/15 moderately impaired cognition Care Area Assessment (CAA) 1/15, revealed R46 required ivities of daily living (ADLs) lity, dressing, toileting and The CAA indicated resident				

STATE FORM

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		07/30/2015		
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE	• •	
OOD SA	AMARITAN SOCIETY	2 - WINTHROP 506 HIGH WINTHROP WINTHRO	DP, MN 55396			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE ⁻ DATE
21810	Continued From page 15		21810			
	was at risk for falls related to difficulty maintaining sitting balance and impaired balance during transitions. R46's care plan dated 6/2/15, indicated resident had an ADL self-care performance deficit and required cues for proper performance. The care plan also indicated resident was at risk for falls related to weakness. Staff was directed to review and modify environmental hazards that could have caused or contributed to falls.					
		5 a.m. LPN-A stated when al pumps on his legs he should sistance.				
	consultant director when resident was	59 a.m. when asked the of nursing (CDON) stated in his room, the call light within reach whether R46 was air.				
	leaving the room, preach of resident if	procedure directed staff, "When blace call light within easy in bed. If out of bed, stretch ss bed so resident is able to				
	The director of nur that policy and pro- staff are trained an	THOD OF CORRECTION: sing or designee could assure cedures are up to date, that id that call lights are monitored in reach and accessible to the				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				