MINNESOTA MDH DEPARTMENT OF HEALTH

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) Drug Regimen Review: (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 physcian, 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.

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,

Gail 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a call light was within reach for 1 of 1 resident (R46) whose call light was out of reach during a specialized treatment. Findings include: On 7/28/15 at 9:55 a.m., R46 was observed to be awake sitting up in his recliner, with arterial	F 246	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 up	9/7/15

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

Electronically Signed | 08/22/2015

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F 246	Continued From page 1 pumps on both legs. The call light cord was hanging on R46's grab bar and not within reach should the resident have needed assistance from staff. A licensed practical nurse (LPN)-A entered the room and the resident's call light position was pointed out to the LPN. LPN-A stated, "No, it is not within reach" and moved it to the recliner armrest. LPN-A stated the call light should have been within the resident's reach, and R46 stated he could then reach and use the call light. R46's admission Minimum Data Set dated 6/9/15, indicated R46 had moderately impaired cognition. The corresponding Care Area Assessment (CAA) analysis dated 6/14/15, revealed R46 required assistance with activities of daily living (ADLs) including bed mobility, dressing, toileting and personal hygiene. The CAA indicated resident 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. On 7/28/15, at 9:55 a.m. LPN-A stated when resident had arterial pumps on his legs he should use call light for assistance. On 7/28/15, at 10:59 a.m. when asked the consultant director of nursing (CDON) stated when resident was in his room, the call light should have been within reach whether R46 was in bed or in the chair.	F 246	education will be completed by 9-7-15. Call light audits will be completed 3x per week x 4 weeks, then monthly x3 by the DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion is 9/07/15.	

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F 246	Continued From page 2 A 9/12, Call Light procedure directed staff, "When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it."	F 246		
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documen[illegible] review the facility failed to ensure clean and sanitary bed linens were provided as needed for of 1 resident (R5) reviewed for activites of daily living. Findings included: On 7/28/15, at 10:08 a.m. during R5's hoo[illegible] observations the fitted sheet was noted to have a large brown smear, by the right grab bar. On 7/29/15 at 7:20 a.m. R5 was observed to be wheeled to the dining room in a wheelchair. After the meal, at 8:20 a.m., with staff assistance R5 was transferred back to her room and assisted into the recliner chair. During this observation, the fitted sheet on R5's bed was still soiled with a large brown smear, up near the bed rail. On 7/29/15, at 9:22 a.m. licensed practical nurse (LPN)-B, during a subsequent tour to the room, verified the brown smear on bedsheet near the	F 254	F-254 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 not attending the meeting, make up education will be completed by 9-7-15. Bed linen audits will be completed 3x per 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.	9/7/15

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F 254	Continued From page 3 grab bar. LPN-B explained that even though it was not R5's bath day, the linen should have been changed. LPN-B stated she would have the nursing assistant change it. During interview, at 9:27 a.m., the consultant director of nursing (CDON) commented that the brown smear on the sheet appeared to be fecal matter and stated the bed sheet should have been changed.	F 254		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was followed for 1 of 3 residents (R10) reviewed for non-pressure skin concerns. Findings included: R10's care plan dated 5/24/15, directed staff R10 was prescribed an anticoagulant (blood thinning medication known to contribute to bruising). Interventions included monitoring for bruising. R10 was observed to have 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	F 282	F282 Resident #10 had an assessment 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 by 8-28-15. Nursing staff will be educated on the GSS policy and procedure for skin assessment, 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 skin assessments will be completed 3x per week x 4 weeks, then monthly x3 by the	9/7/15

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F 282	Continued From page 4 to the left forearm. At 9:07 a.m. the consultant director of nursing (CDON) with the surveyor looked at R10's arms. The CDON verified the presence of bruising and skin tears on the resident's arms. On 7/29/15, at 9:14 a.m. the CDON reviewed progress notes from 7/1/15 and verified there was no documentation related to R10's skin issues. The DON stated it was expected the NAs would report any skin changes to the charge nurse. At 9:26 a.m. the CDON asked a licensed practical nurse (LPN)-A if she noticed the bruising on the left forearm or if R10 had been found on his left side when he recently fell. LPN-A replied, "No. The only thing we had noticed was after the fall were the skin tears on the right arm and by the elbow and he was found on his right side." When LPN-A was asked by CDON if she had received any report of injuries LPN-A denied receipt of any reports. A nursing assistant (NA)-A then reported at 9:40 a.m. R10 had experienced a fall recently, which she thought caused the bruising and skin tears. NA-A explained that the NAs were supposed to report any changes in skin conditions, but thought it had been reported and investigated, as the bruising had been present on R10's arm since Monday.	F 282	DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion is 9/07/15.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		9/7/15

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F 309	Continued From page 5 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify non-pressure related skin conditions for 1 of 3 residents (R10) with observed bruising. 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 nursing (CDON) with the surveyor looked at R10's arms. The CDON verified the presence of bruising and skin tears on the resident's arms. R10's care plan dated 5/24/15, indicated the resident was prescribed an anticoagulant (blood thinning medication known to contribute to bruising). Interventions included monitoring for bruising. R10's 6/2/15, quarterly Minimum Data Set (MDS) indicated the resident had severely impaired cognition. Progress Notes dated 7/1/15 though 7/29/15, revealed no documentation related to alterations in the resident's arms. On 7/29/15, at 9:14 a.m. the CDON reviewed progress notes from 7/1/15 and verified there was no documentation related to R10's skin issues. The DON stated it was expected the NAs would report any skin changes to the charge nurse.	F 309	F309 Resident #10 had an assessment and care plan review/update related to bruising on 8-21-15. All residents will have a skin UDA, record review, and ensure appropriate care planning is complete by 9-07-15. Nursing staff will be educated on the GSS policy and procedure for skin assessment, 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 skin assessments will be completed 3x per week x 4 weeks, then monthly x3 by the DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion is 9/07/15.	

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F 309	Continued From page 6	F 309		

At 9:26 a.m. the CDON asked a licensed practical nurse (LPN)-A if she noticed the bruising on the left forearm or if R10 had been found on his left side when he recently fell. LPN-A replied, "No. The only thing we had noticed was after the fall were the skin tears on the right arm and by the elbow and he was found on his right side." When LPN-A was asked by CDON if she had received any report of injuries LPN-A denied receipt of any reports.

A nursing assistant (NA)-A then reported at 9:40 a.m. R10 had experienced a fall recently, which she thought caused the bruises and skin tears. NA-A explained that the NAs were supposed to report any changes in skin conditions, but thought it had been reported and investigated, as the bruising had been present on R10's arm since Monday.

After the concern was brought to the staffs' attention, an incident report dated 5/15/15, noted the presence of a bruise on R10's left forearm measuring 4.5 x 3.0 centimeters (cm).

A 5/15, Skin Assessment, Pressure Ulcer Prevention And Documentation Requirements policy under Assessment and Documentation of Bruises/Contusions/Skin tears/Abrasions read: "If a bruise, contusion, abrasion or skin tear is observed on a resident, this should be reported to the nurse immediately...The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation UDA [unknown acronym] and on the resident's care plan...."

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F 328	Continued From page 7	F 328		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the continuous positive airway pressure (C-PAP breathing machine providing air for sleep apnea) machine and mask were cleaned for 1 of 1 residents (R5) who utilized a CPAP machine. Findings include: R5's room was observed on 7/28/15, at 10:08 a.m. A C-PAP machine and the long tubing attached to the nose piece was stored on top of a bedside adjacent to R5's bed. The mask had a creamy white/brown build up in the inside of the mask and around the seams. On 7/29/15, at 8:20 a.m. C-PAP nasal piece mask continued to have a thick creamy/brown build up on the inside and the seams. R5 had a physician's order dated 10/13/11,	F 328	F328 Resident #5 CPAP machine equipment has been cleaned. All residents that are on CPAP have also had their CPAP items cleaned. The manufacturer¿s direction for cleaning has been added to the TAR to ensure they are cleaned daily / weekly per the recommendations. Care plans have been 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 attending the meeting, make up education will be completed by 9-7-15. CPAP cleanliness audits will be completed weekly x 4 weeks, then monthly x3 by the DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion 9/07/15	9/7/15

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F 328	Continued From page 8 directing "C-PAP at night one time a day related to obstructive sleep apnea." A psychopharmacological medication and antidepressant medication care plan dated 4/10/14, directed staff to provide sleep encouragement techniques which included applying the C-PAP machine mask at bedtime. In addition, direction was provided to staff to clean the C-PAP weekly. A 7/29/15, Admission Record revealed R5 had diagnoses including obstructive sleep apnea (complete or partial blockage of upper airway during sleep), insomnia (inability to fall asleep or stay asleep and narcolepsy (poor control of sleep wake cycles). A nursing assistant (NA)-C explained on 7/29/15, at 9:19 a.m. that the cleaning of R5's C-PAP machine involved, "General care--rinse out and leave to dry." NA-C was unsure of the facility policy regarding cleaning of C-PAP machines. At 9:27 a.m. the consultant director of nursing (CDON) then verified debris in R5's C-PAP mask and acknowledged it was not clean. Later, at 10:15 a.m. the CDON reported, "I doubt we have a policy for CPAP cleaning. It says to follow the manufacturer's instructions." A 9/12 C-PAP Therapy policy directed staff to "Please refer to the manufacturer's instructions." The manufacturer Phillips Respironics 2014 instructions indicated masks should have been cleaned daily and headgear at least weekly in warm soapy water.	F 328		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		9/7/15

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F 334	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 has already been immunized during this time period; (iii) The resident 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 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334		

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F 334	Continued From page 10 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, 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 pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R41) was offered and/or received pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: R41's undated Admission Record indicated R41 was admitted to the facility on 10/3/14.	F 334	F 334 The pneumococcal vaccine for Resident # 41 was reviewed with the MD/NP and the recommendation is that the vaccine is not indicated for a 36 year old female with no respiratory history. The resident was informed and in agreement. A review of all the resident charts is completed to ensure the proper pneumococcal vaccinations were offered by 8-28-15. New admission charts will be reviewed at the time of admission.	

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	245314	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 11 Review of R41's immunization record lacked documentation if a pneumococcal vaccination had been received, contraindicated or refused. On 7/29/15, at 3:53 p.m. when asked for additional information for R41's immunization the administrator stated "from what I understand it wasn't offered or given because of her age. I don't know what was said to her back in October. I can't find risks or benefits yet." Review of the Good Samaritan Society Immunizations for Residents policy dated 2/15, indicated that upon admission, each resident and/or legal representative will receive the Vaccination Information Statements for influenza and pneumococcal vaccines and the benefits and potential side effects of vaccinations will be discussed with the resident. The policy further indicated "if the resident received a pneumococcal vaccination before age 65 determine if it has been five years since that vaccination. Pneumococcal vaccination is indicated for those residents if it has been five years or longer since primary vaccination."	F 334	Licensed staff will be educated to ensure they are offering the proper vaccines upon admission by 8-27-15. For those not attending the meeting, make up education will be completed by 9-7-15. Pneumococcal audits will be completed weekly for new admits x 4 weeks, then monthly x3 by the DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion 9/07/15.	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and	F 465	F465 Resident #4, 5, and 14 have had their living environment inspected and	9/7/15

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F 465	Continued From page 12 sanitary environment was maintained, which had the potential to affect 3 of 28 residents (R14, R5, R4) who resided in resident rooms observed during the environmental tour. Findings include: During an environmental tour on 7/29/15, at 1:31 p.m., with the environmental services supervisor (ESS), the following environmental concerns were noted and verified: On 7/28/15, R14's toilet seat, behind risers, was observed to be stained and an odor was detected. During the tour ESS verified the stain and the need for cleaning. ESS stated staff would clean it and if the stain did not come off, the toilet seat would be replaced. On 7/28/15, R5's bathroom was observed to have a strong odor in the shared bathroom. During the tour ESS explained that R5's roommate (R4) used a lot of toilet paper and used the bathroom garbage for the toilet paper, instead of the toilet. ESS also stated that R5 throws the incontinent pad in the garbage and if staff doesn't empty the garbage, the bathroom has an odor. On 7/29/15, ESS identified that the maintenance clipboard, located at the nurse's station, was for staff to write environmental concerns. ESS also stated the cleaning schedule for cleaning all rooms and toilets was daily. On 7/30/15, at 9:08 a.m. when interviewed, nursing assistant (NA)-B stated if she had an environmental concern, she would notify environmental services. If unavailable, she would notify the charge nurse. If neither were available,	F 465	cleaned as appropriate. All residents have the potential to be affected by this same deficient practice. All resident rooms were inspected to ensure a clean and sanitary environment by 8-28-15. Nursing, housekeeping, and environmental service staff will be educated on the CSS Policy and procedure for a clean and sanitary environment and a cleaning schedule will be implemented by 8-28-15. For those not attending the meeting, make up education will be completed by 9-7-15. Environmental audits will be completed weekly x 4 weeks, then monthly x3 by the DNS/ESS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion 9/07/15.	

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F 465	Continued From page 13 she would write the concern on the maintenance clipboard. At 9:17 a.m., when interviewed, the licensed practical nurse (LPN)-B stated if she had an environmental concern she would write it on the clipboard and if necessary, would call them. The facility cleaning of common areas policy dated December 2008, revised 6/14, indicated: ..."3. All parts of the community will be kept clean, neat and free of litter. 7. Clean surfaces as often as necessary to keep furniture and equipment free of accumulations of dust, dirt, food particles, etc. 15. Empty bathroom wastebaskets daily or as needed. Disinfect as needed."	F 465		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245314	A. Building B. Wing	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** Reg. # **483.15(e)(1)** LSC	Correction Completed **09/07/2015**	ID Prefix **F0254** Reg. # **483.15(h)(3)** LSC	Correction Completed **09/07/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/07/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/07/2015**	ID Prefix **F0328** Reg. # **483.25(k)** LSC	Correction Completed **09/07/2015**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/07/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/07/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/kfd	11/02/2015	18623	09/14/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/30/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 # S4302

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.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00961	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On July 27th to July 30th 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and

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2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was followed for 1 of 3 residents (R10) reviewed for non-pressure skin concerns. Findings included: R10's care plan dated 5/24/15, directed staff R10 was prescribed an anticoagulant (blood thinning medication known to contribute to bruising). Interventions included monitoring for bruising. R10 was observed to have 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 nursing (CDON) with the surveyor looked at R10's arms. The CDON verified the presence of bruising and skin tears on the resident's arms. On 7/29/15, at 9:14 a.m. the CDON reviewed	2 565	Corrected	9/7/15

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2 565	Continued From page 2	2 565		

progress notes from 7/1/15 and verified there was no documentation related to R10's skin issues. The DON stated it was expected the NAs would report any skin changes to the charge nurse.

At 9:26 a.m. the CDON asked a licensed practical nurse (LPN)-A if she noticed the bruising on the left forearm or if R10 had been found on his left side when he recently fell. LPN-A replied, "No. The only thing we had noticed was after the fall were the skin tears on the right arm and by the elbow and he was found on his right side." When LPN-A was asked by CDON if she had received any report of injuries LPN-A denied receipt of any reports.

A nursing assistant (NA)-A then reported at 9:40 a.m. R10 had experienced a fall recently, which she thought caused the bruises and skin tears. NA-A explained that the NAs were supposed to report any changes in skin conditions, but thought it had been reported and investigated, as the bruising had been present on R10's arm since Monday.

SUGGESTED METHOD OF CORRECTION:

The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 565	Continued From page 3 (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and 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 evidenced by: Based on observation, interview and document review, the facility failed to identify non-pressure related skin conditions for 1 of 4 residents (R10) with observed bruising and failed to ensure the continuous positive airway pressure (C-PAP breathing machine providing air for sleep apnea) machine and mask were cleaned for 1 of 1 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	2 830	Corrected	9/7/15

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2 830	Continued From page 4 nursing (CDON) with the surveyor looked at R10's arms. The CDON verified the presence of bruising and skin tears on the resident's arms. R10's care plan dated 5/24/15, indicated the resident was prescribed an anticoagulant (blood thinning medication known to contribute to bruising). Interventions included monitoring for bruising. R10's 6/2/15, quarterly Minimum Data Set (MDS) indicated the resident had severely impaired cognition. Progress Notes dated 7/1/15 though 7/29/15, revealed no documentation related to alterations in the resident's arms. On 7/29/15, at 9:14 a.m. the CDON reviewed progress notes from 7/1/15 and verified there was no documentation related to R10's skin issues. The DON stated it was expected the NAs would report any skin changes to the charge nurse. At 9:26 a.m. the CDON asked a licensed practical nurse (LPN)-A if she noticed the bruising on the left forearm or if R10 had been found on his left side when he recently fell. LPN-A replied, "No. The only thing we had noticed with the fall were the skin tears on the right arm and by the elbow and he was found on his right side." When LPN-A was asked by CDON if she had received any report of injuries LPN-A denied receipt of any reports. A nursing assistant (NA)-A then reported at 9:40 a.m. R10 had experienced a fall recently, which she thought caused the bruises and skin tears. NA-A explained that the NAs were supposed to report any changes in skin conditions, but thought it had been reported and investigated, as the bruising had been present on R10's arm since Monday.	2 830		

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2 830	Continued From page 5 After the concern was brought to the staffs' attention, an incident report dated 7/29/15, noted the presence of a bruise on R10's left forearm measuring 4.5 x 3.0 centimeters (cm). A 5/15, Skin Assessment, Pressure Ulcer Prevention And Documentation Requirements policy under Assessment and Documentation of Bruises/Contusions/Skin tears/Abrasions read: "If a bruise, contusion, abrasion or skin tear is observed on a resident, this should be reported to the nurse immediately...The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation UDA [unknown acronym] and on the resident's care plan...." R5's room was observed on 7/28/15, at 10:08 a.m. A C-PAP machine and the long tubing attached to the nose piece was stored on top of a bedside adjacent to R5's bed. The mask had a creamy white/brown build up in the inside of the mask and around the seams. On 7/29/15, at 8:20 a.m. C-PAP nasal piece mask continued to have a thick creamy brown build up on the inside and the seams. R5 had a physician's order dated 10/13/11, directing "C-PAP at night one time a day related to obstructive sleep apnea." A psychopharmacological medication and antidepressant medication care plan dated 4/10/14, directed staff to provide sleep encouragement techniques which included applying the C-PAP machine mask at bedtime. In addition, direction was provided to staff to clean the C-PAP weekly.	2 830		

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2 830	Continued From page 6 A 7/29/15, Admission Record revealed R5 had diagnoses including obstructive sleep apnea (complete or partial blockage of upper airway during sleep), insomnia (inability to fall asleep or stay asleep and narcolepsy (poor control of sleep wake cycles). A nursing assistant (NA)-C explained on 7/29/15, at 9:19 a.m. that the cleaning of R5's C-PAP machine involved, "General care--rinse out and leave to dry." NA-C was unsure of the facility policy regarding cleaning of C-PAP machines. At 9:27 a.m. the consultant director of nursing (CDON) then verified debris in R15's C-PAP mask and acknowledged it was not clean. Later, at 10:15 a.m. the CDON reported, "I doubt we have a policy for CPAP cleaning. It says to follow the manufacturer's instructions." A 9/12 C-PAP Therapy policy directed staff to "Please refer to the manufacturer instructions. The manufacturer Phillips Respironics 2014 instructions indicated masks should be cleaned daily and headgear at least weekly in warm soapy water. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies/procedures, train staff and monitor to assure residents and their equipment are appropriately monitored. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of adequate intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clean and sanitary bed linens were provided as needed for 1 of 1 resident (R5) reviewed for activites of daily living. Findings included: On 7/28/15, at 10:08 a.m. during R5's room observations the fitted sheet was noted to have a large brown smear, by the right grab bar.	21670	Corrected	9/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00961	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21670	Continued From page 8 On 7/29/15 at 7:20 a.m. R5 was observed to be wheeled to the dining room in a wheelchair. After the meal, at 8:20 a.m., with staff assistance R5 was transferred back to her room and assisted into the recliner chair. During this observation, the fitted sheet on R5's bed was still soiled with a large brown smear, up near the bed rail. On 7/29/15, at 9:22 a.m. licensed practical nurse (LPN)-B, during a subsequent tour to the room, verified the brown smear on bedsheet near the grab bar. LPN-B explained that even though it was not R5's bath day, the linen should have been changed. LPN-B stated she would have the nursing assistant change it. During interview, at 9:27 a.m., the consultant director of nursing (CDON) commented that th brown smear on the sheet appeared to be fecal matter and stated the bed sheet should have been changed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies/procedures, provide staff training and monitor to assure bed linens are clean for the residents use. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21670		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services	21695		9/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00961	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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21695	Continued From page 9 necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and sanitary environment was maintained, which had the potential to affect 3 of 28 residents (R14, R5, R4) who resided in resident rooms observed during the environmental tour. Findings include: During an environmental tour on 7/29/15, at 1:31 p.m., with the environmental services supervis (ESS), the following environmental concer were noted and verified: On 7/28/15, R14's toilet sea, per d ris s, wa observed to be stained a d an od was detected. During the tou ESS y the stain and the need for cleaning. stated staff would clean it and if the stain did no ome off, the toilet seat would be replaced. On 7/28/15, R5's bathroom was observed to have a strong odor in the shared bathroom. During the tour ESS explained that R5's roommate (R4) used a lot of toilet paper and used the bathroom garbage for the toilet paper, instead of the toilet. ESS also stated that R5 throws the incontinent pad in the garbage and if staff doesn't empty the garbage, the bathroom has an odor. On 7/29/15, ESS identified that the maintenance clipboard, located at the nurse's station, was for	21695	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00961	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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21695	Continued From page 10 staff to write environmental concerns. ESS also stated the cleaning schedule for cleaning all rooms and toilets was daily. On 7/30/15, at 9:08 a.m. when interviewed, nursing assistant (NA)-B stated if she had an environmental concern, she would notify environmental services. If unavailable, she would notify the charge nurse. If neither were available, she would write the concern on the maintenance clipboard. At 9:17 a.m., when interviewed, the licensed practical nurse (LPN)-B stated if she had an environmental concern she would write it on the clipboard or if necessary, would call them. The facility cleaning of common areas policy dated December 2008, revised 6/14, indicated: ..."3. All parts of the community will be kept clean, neat and free of litter. 7. Clean surfaces as often as necessary to keep furniture and equipment free of accumulations of dust, dirt, food particles, etc. 15. Empty bathroom wastebaskets daily or as needed. Disinfect as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing, maintenance, housekeeping or designee could assure that bathroom toilets are in working order, clean and that bathrooms are odor free. Policy and procedures could be reviewed and staff trained to assure appropriate departments are notified. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and	21810		9/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00961	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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21810	Continued From page 11 residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a call light was within reach for 1 of 1 resident (R46) whose call light was out of reach during a specialized treatment. Findings include: On 7/28/15 at 9:55 a.m., R46 was observed to be awake sitting up in his recliner with arterial pumps on both legs. The call light cord was hanging on R46's grab bar and not within reach should the resident have needed assistance from staff. A licensed practical nurse (LPN)-A entered the room and the resident's call light position was pointed out to the LPN. LPN-A stated, "No, it is not within reach" and moved it to the recliner armrest. LPN-A stated the call light should have been within the resident's reach, and R46 stated he could then reach and use the call light. R46's admission Minimum Data Set dated 6/9/15, indicated R46 had moderately impaired cognition. The corresponding Care Area Assessment (CAA) analysis dated 6/14/15, revealed R46 required assistance with activities of daily living (ADLs) including bed mobility, dressing, toileting and personal hygiene. The CAA indicated resident	21810	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00961	A. BUILDING: _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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21810	Continued From page 12 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. On 7/28/15, at 9:55 a.m. LPN-A stated when resident had arterial pumps on his legs he should use call light for assistance. On 7/28/15, at 10:59 a.m. when asked the consultant director of nursing (CDON) stated when resident was in his room, the call light should have been within reach whether R46 was in bed or in the chair. A 9/12, Call Light procedure directed staff "When leaving the room, place call light within easy reach of resident if in bed. If out of bed stretch call light cord across bed so resident is able to reach it." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure that policy and procedures are up to date, that staff are trained and that call lights are monitored to assure they are in reach and accessible to the residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2CND

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00961

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245314**
2.STATE VENDOR OR MEDICAID NO.
(L2) **841820900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINTHROP**
(L4) **506 HIGH STREET**
(L5) **WINTHROP, MN** (L6) **55396**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/14/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 10/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/10/2015
(L33)

DETERMINATION APPROVAL

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
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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))

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 https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

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.

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: 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.

Feel free to contact me if you have questions.

Sincerely,

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245314	A. Building B. Wing	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** Reg. # **483.15(e)(1)** LSC	Correction Completed **09/07/2015**	ID Prefix **F0254** Reg. # **483.15(h)(3)** LSC	Correction Completed **09/07/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/07/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/07/2015**	ID Prefix **F0328** Reg. # **483.25(k)** LSC	Correction Completed **09/07/2015**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **09/07/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/07/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/07/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/kfd	10/15/2015	18623	09/14/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/30/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245314	A. Building B. Wing **01 - MAIN BUILDING 01**	10/5/2015

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	Correction Completed **09/07/2015**	ID Prefix	Correction Completed **10/03/2015**	ID Prefix	Correction Completed **09/07/2015**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0027		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **09/07/2015**	ID Prefix	Correction Completed **09/07/2015**	ID Prefix	Correction Completed **09/07/2015**
Reg. # **NFPA 101** LSC K0054		Reg. # **NFPA 101** LSC K0056		Reg. # **NFPA 101** LSC K0062	
ID Prefix	Correction Completed **09/07/2015**	ID Prefix	Correction Completed **09/07/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0067		Reg. # **NFPA 101** LSC K0069		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/kfd	10/15/2015	34764	10/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/28/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245314	A. Building B. Wing **02 - 2006 ADDITION**	10/5/2015

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	Correction Completed **09/07/2015**	ID Prefix	Correction Completed **09/07/2015**	ID Prefix	Correction Completed **09/07/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0018		LSC K0029		LSC K0050	
ID Prefix	Correction Completed **09/07/2015**	ID Prefix	Correction Completed **09/07/2015**	ID Prefix	Correction Completed **09/07/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0054		LSC K0062		LSC K0067	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/kfd	10/15/2015	34764	10/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/28/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2CND

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00961

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245314**
2.STATE VENDOR OR MEDICAID NO.
(L2) **841820900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINTHROP**
(L4) **506 HIGH STREET**
(L5) **WINTHROP, MN** (L6) **55396**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **37** (L18)

13.Total Certified Beds **37** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	37			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a call light was within reach for 1 of 1 resident (R46) whose call light was out of reach during a specialized treatment. Findings include: On 7/28/15 at 9:55 a.m., R46 was observed to be awake sitting up in his recliner, with arterial	F 246	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 up	9/7/15

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

Electronically Signed | 08/22/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 1 pumps on both legs. The call light cord was hanging on R46's grab bar and not within reach should the resident have needed assistance from staff. A licensed practical nurse (LPN)-A entered the room and the resident's call light position was pointed out to the LPN. LPN-A stated, "No, it is not within reach" and moved it to the recliner armrest. LPN-A stated the call light should have been within the resident's reach, and R46 stated he could then reach and use the call light. R46's admission Minimum Data Set dated 6/9/15, indicated R46 had moderately impaired cognition. The corresponding Care Area Assessment (CAA) analysis dated 6/14/15, revealed R46 required assistance with activities of daily living (ADLs) including bed mobility, dressing, toileting and personal hygiene. The CAA indicated resident 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. On 7/28/15, at 9:55 a.m. LPN-A stated when resident had arterial pumps on his legs he should use call light for assistance. On 7/28/15, at 10:59 a.m. when asked the consultant director of nursing (CDON) stated when resident was in his room, the call light should have been within reach whether R46 was in bed or in the chair.	F 246	education will be completed by 9-7-15. Call light audits will be completed 3x per week x 4 weeks, then monthly x3 by the DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion is 9/07/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 2 A 9/12, Call Light procedure directed staff, "When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it."	F 246		
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clean and sanitary bed linens were provided as needed for 1 of 1 resident (R5) reviewed for activites of daily living. Findings included: On 7/28/15, at 10:08 a.m. during R5's room observations the fitted sheet was noted to have a large brown smear, by the right grab bar. On 7/29/15 at 7:20 a.m. R5 was observed to be wheeled to the dining room in a wheelchair. After the meal, at 8:20 a.m., with staff assistance R5 was transferred back to her room and assisted into the recliner chair. During this observation, the fitted sheet on R5's bed was still soiled with a large brown smear, up near the bed rail. On 7/29/15, at 9:22 a.m. licensed practical nurse (LPN)-B, during a subsequent tour to the room, verified the brown smear on bedsheet near the	F 254	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 not attending the meeting, make up education will be completed by 9-7-15. Bed linen audits will be completed 3x per 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.	9/7/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	07/30/2015

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GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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F 254	Continued From page 3 grab bar. LPN-B explained that even though it was not R5's bath day, the linen should have been changed. LPN-B stated she would have the nursing assistant change it. During interview, at 9:27 a.m., the consultant director of nursing (CDON) commented that the brown smear on the sheet appeared to be fecal matter and stated the bed sheet should have been changed.	F 254		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was followed for 1 of 3 residents (R10) reviewed for non-pressure skin concerns. Findings included: R10's care plan dated 5/24/15, directed staff R10 was prescribed an anticoagulant (blood thinning medication known to contribute to bruising). Interventions included monitoring for bruising. R10 was observed to have 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	F 282	F282 Resident #10 had an assessment 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 by 8-28-15. Nursing staff will be educated on the GSS policy and procedure for skin assessment, 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 skin assessments will be completed 3x per week x 4 weeks, then monthly x3 by the	9/7/15

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F 282	Continued From page 4 to the left forearm. At 9:07 a.m. the consultant director of nursing (CDON) with the surveyor looked at R10's arms. The CDON verified the presence of bruising and skin tears on the resident's arms. On 7/29/15, at 9:14 a.m. the CDON reviewed progress notes from 7/1/15 and verified there was no documentation related to R10's skin issues. The DON stated it was expected the NAs would report any skin changes to the charge nurse. At 9:26 a.m. the CDON asked a licensed practical nurse (LPN)-A if she noticed the bruising on the left forearm or if R10 had been found on his left side when he recently fell. LPN-A replied, "No. The only thing we had noticed was after the fall were the skin tears on the right arm and by the elbow and he was found on his right side." When LPN-A was asked by CDON if she had received any report of injuries LPN-A denied receipt of any reports. A nursing assistant (NA)-A then reported at 9:40 a.m. R10 had experienced a fall recently, which she thought caused the bruises and skin tears. NA-A explained that the NAs were supposed to report any changes in skin conditions, but thought it had been reported and investigated, as the bruising had been present on R10's arm since Monday.	F 282	DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion is 9/07/15.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309		9/7/15

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	245314	A. BUILDING _____ B. WING _____	07/30/2015

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F 309	Continued From page 5 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify non-pressure related skin conditions for 1 of 3 residents (R10) with observed bruising. 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 nursing (CDON) with the surveyor looked at R10's arms. The CDON verified the presence of bruising and skin tears on the resident's arms. R10's care plan dated 5/24/15, indicated the resident was prescribed an anticoagulant (blood thinning medication known to contribute to bruising). Interventions included monitoring for bruising. R10's 6/2/15, quarterly Minimum Data Set (MDS) indicated the resident had severely impaired cognition. Progress Notes dated 7/1/15 though 7/29/15, revealed no documentation related to alterations in the resident's arms. On 7/29/15, at 9:14 a.m. the CDON reviewed progress notes from 7/1/15 and verified there was no documentation related to R10's skin issues. The DON stated it was expected the NAs would report any skin changes to the charge nurse.	F 309	F309 Resident #10 had an assessment and care plan review/update related to bruising on 8-21-15. All residents will have a skin UDA, record review, and ensure appropriate care planning is complete by 9-07-15. Nursing staff will be educated on the GSS policy and procedure for skin assessment, 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 skin assessments will be completed 3x per week x 4 weeks, then monthly x3 by the DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion is 9/07/15.	

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F 309	Continued From page 6	F 309		

At 9:26 a.m. the CDON asked a licensed practical nurse (LPN)-A if she noticed the bruising on the left forearm or if R10 had been found on his left side when he recently fell. LPN-A replied, "No. The only thing we had noticed was after the fall were the skin tears on the right arm and by the elbow and he was found on his right side." When LPN-A was asked by CDON if she had received any report of injuries LPN-A denied receipt of any reports.

A nursing assistant (NA)-A then reported at 9:40 a.m. R10 had experienced a fall recently, which she thought caused the bruises and skin tears. NA-A explained that the NAs were supposed to report any changes in skin conditions, but thought it had been reported and investigated, as the bruising had been present on R10's arm since Monday.

After the concern was brought to the staffs' attention, an incident report dated 7/29/15, noted the presence of a bruise on R10's left forearm measuring 4.5 x 3.0 centimeters (cm).

A 5/15, Skin Assessment, Pressure Ulcer Prevention And Documentation Requirements policy under Assessment and Documentation of Bruises/Contusions/Skin tears/Abrasions read: "If a bruise, contusion, abrasion or skin tear is observed on a resident, this should be reported to the nurse immediately...The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation UDA [unknown acronym] and on the resident's care plan...."

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F 328	Continued From page 7	F 328		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the continuous positive airway pressure (C-PAP breathing machine providing air for sleep apnea) machine and mask were cleaned for 1 of 1 residents (R5) who utilized a CPAP machine. Findings include: R5's room was observed on 7/28/15, at 10:08 a.m. A C-PAP machine and the long tubing attached to the nose piece was stored on top of a bedside adjacent to R5's bed. The mask had a creamy white/brown build up in the inside of the mask and around the seams. On 7/29/15, at 8:20 a.m. C-PAP nasal piece mask continued to have a thick creamy/brown build up on the inside and the seams. R5 had a physician's order dated 10/13/11,	F 328	F328 Resident #5 CPAP machine equipment has been cleaned. All residents that are on CPAP have also had their CPAP items cleaned. The manufacturer¿s direction for cleaning has been added to the TAR to ensure they are cleaned daily / weekly per the recommendations. Care plans have been 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 attending the meeting, make up education will be completed by 9-7-15. CPAP cleanliness audits will be completed weekly x 4 weeks, then monthly x3 by the DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion 9/07/15	9/7/15

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F 328	Continued From page 8 directing "C-PAP at night one time a day related to obstructive sleep apnea." A psychopharmacological medication and antidepressant medication care plan dated 4/10/14, directed staff to provide sleep encouragement techniques which included applying the C-PAP machine mask at bedtime. In addition, direction was provided to staff to clean the C-PAP weekly. A 7/29/15, Admission Record revealed R5 had diagnoses including obstructive sleep apnea (complete or partial blockage of upper airway during sleep), insomnia (inability to fall asleep or stay asleep and narcolepsy (poor control of sleep wake cycles). A nursing assistant (NA)-C explained on 7/29/15, at 9:19 a.m. that the cleaning of R5's C-PAP machine involved, "General care--rinse out and leave to dry." NA-C was unsure of the facility policy regarding cleaning of C-PAP machines. At 9:27 a.m. the consultant director of nursing (CDON) then verified debris in R15's C-PAP mask and acknowledged it was not clean. Later, at 10:15 a.m. the CDON reported, "I doubt we have a policy for CPAP cleaning. It says to follow the manufacturer's instructions." A 9/12 C-PAP Therapy policy directed staff to "Please refer to the manufacturer's instructions." The manufacturer Phillips Respironics 2014 instructions indicated masks should have been cleaned daily and headgear at least weekly in warm soapy water.	F 328		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		9/7/15

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F 334	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 has already been immunized during this time period; (iii) The resident 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 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	07/30/2015

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F 334	Continued From page 10 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, 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 pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R41) was offered and/or received pneumococcal vaccinations as recommended by Centers for Disease Control (CDC). Findings include: R41's undated Admission Record indicated R41 was admitted to the facility on 10/3/14.	F 334	F 334 The pneumococcal vaccine for Resident # 41 was reviewed with the MD/NP and the recommendation is that the vaccine is not indicated for a 36 year old female with no respiratory history. The resident was informed and in agreement. A review of all the resident charts is completed to ensure the proper pneumococcal vaccinations were offered by 8-28-15. New admission charts will be reviewed at the time of admission.	

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	245314	A. BUILDING _____ B. WING _____	07/30/2015

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F 334	Continued From page 11 Review of R41's immunization record lacked documentation if a pneumococcal vaccination had been received, contraindicated or refused. On 7/29/15, at 3:53 p.m. when asked for additional information for R41's immunization the administrator stated "from what I understand it wasn't offered or given because of her age. I don't know what was said to her back in October. I can't find risks or benefits yet." Review of the Good Samaritan Society Immunizations for Residents policy dated 2/15, indicated that upon admission, each resident and/or legal representative will receive the Vaccination Information Statements for influenza and pneumococcal vaccines and the benefits and potential side effects of vaccinations will be discussed with the resident. The policy further indicated "if the resident received a pneumococcal vaccination before age 65, determine if it has been five years since that vaccination. Pneumococcal vaccination is indicated for those residents if it has been five years or longer since primary vaccination."	F 334	Licensed staff will be educated to ensure they are offering the proper vaccines upon admission by 8-27-15. For those not attending the meeting, make up education will be completed by 9-7-15. Pneumococcal audits will be completed weekly for new admits x 4 weeks, then monthly x3 by the DNS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion 9/07/15.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		9/7/15

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	245314	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure monthly medication reviews were completed for 1 of 5 residents (R30) reviewed for unnecessary medications. Findings include: On 7/29/15, at 9:30 a.m. R30 was observed sleeping in his room. Nursing assistant (NA)-C stated R30 always sleeps in until 10:00 a.m. when they get him up for the day. R30 was admitted to the facility on 1/9/14, with diagnoses including cerebrovascular disease, dementia, and major depressive disorder. Care plan dated 7/31/14, indicated R30 received an antidepressant related to potential for alteration in mood related to diagnosis of depressive disorder evidenced by periods of flat affect, not talking to others. A review of the consultant pharmacist monthly record of drug regimen review indicated reports were not completed for October 2014, December 2014, January 2015, April 2015, June 2015, and July 2015. The Physician Orders dated 7/6/15, indicated R30 received Celexa (anti-depressant) 20 milligram (mg) once daily. The Care Area Assessment (CAA) analysis dated 7/30/15, indicated R30 was on antidepressant	F 428	F428 Resident #30 did receive a monthly pharmacy consult regarding his medication regime for unnecessary drugs which was documented in the progress notes of the chart. Any recommendations were printed by the consultant pharmacist and forwarded to the DNS for follow-up. On 8-21-15 All residents in the facility will receive a pharmacy review by the consultant pharmacist for unnecessary drugs. The consulting pharmacist /DNS upon further discussion noted there are reviews completed each month and the documentation is in the progress notes of the chart. The consultant pharmacist is aware of the regulation and knows that all residents need monthly documentation regarding their monthly review. The DNS/MDS nurse have been educated by the consultant pharmacist on her procedure for documentation. Medication review audits will be completed monthly by the consulting pharmacist/DON for compliance to this regulation x 4 months. The results of the audits will be reported to the Quality Committee for further recommendations. Date of Completion 9/07/15.	

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	245314	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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F 428	Continued From page 13 medication with treatable medical condition such as cerebrovascular accident and had disturbances of balance, gait, positioning ability. On 7/30/15, at 8:30 a.m. consultant pharmacist (CP) stated she would look for monthly medication reviews and call or fax the information. Monthly medication reviews were not provided. On 7/30/15, at 10:10 a.m. the consultant director of nursing (CDON) stated if monthly medication reviews were completed, the facility would have them filed. The unnecessary medications policy dated September 2012, indicated: ..."pharmacy, the center and consultant pharmacist are responsible for identifying orders from multiple prescriber's and assist in determining the use of unnecessary medications."	F 428		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and sanitary environment was maintained, which had the potential to affect 3 of 28 residents (R14, R5, R4) who resided in resident rooms observed during the environmental tour.	F 465	F465 Resident #4, 5, and 14 have had their living environment inspected and cleaned as appropriate. All residents have the potential to be affected by this same deficient practice. All resident rooms were inspected to	9/7/15

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F 465	Continued From page 14 Findings include: During an environmental tour on 7/29/15, at 1:31 p.m., with the environmental services supervisor (ESS), the following environmental concerns were noted and verified: On 7/28/15, R14's toilet seat, behind risers, was observed to be stained and an odor was detected. During the tour ESS verified the stain and the need for cleaning. ESS stated staff would clean it and if the stain did not come off, the toilet seat would be replaced. On 7/28/15, R5's bathroom was observed to have a strong odor in the shared bathroom. During the tour ESS explained that R5's roommate (R4) used a lot of toilet paper and used the bathroom garbage for the toilet paper, instead of the toilet. ESS also stated that R5 throws the incontinent pad in the garbage and if staff doesn't empty the garbage, the bathroom has an odor. On 7/29/15, ESS identified that the maintenance clipboard, located at the nurse's station, was for staff to write environmental concerns. ESS also stated the cleaning schedule for cleaning all rooms and toilets was daily. On 7/30/15, at 9:08 a.m. when interviewed, nursing assistant (NA)-B stated if she had an environmental concern, she would notify environmental services. If unavailable, she would notify the charge nurse. If neither were available, she would write the concern on the maintenance clipboard. At 9:17 a.m., when interviewed, the licensed practical nurse (LPN)-B stated if she had an environmental concern she would write it on	F 465	ensure a clean and sanitary environment by 8-28-15. Nursing, housekeeping, and environmental service staff will be educated on the GSS Policy and procedure for a clean and sanitary environment and a cleaning schedule will be implemented by 8-28-15. For those not attending the meeting, make up education will be completed by 9-7-15. Environmental audits will be completed weekly x 4 weeks, then monthly x3 by the DNS/ESS or designee. The results of these audits will be presented to the Quality Committee for further recommendations. Date of completion 9/07/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 15 the clipboard and if necessary, would call them. The facility cleaning of common areas policy dated December 2008, revised 6/14, indicated: ..."3. All parts of the community will be kept clean, neat and free of litter. 7. Clean surfaces as often as necessary to keep furniture and equipment free of accumulations of dust, dirt, food particles, etc. 15. Empty bathroom wastebaskets daily or as needed. Disinfect as needed."	F 465		

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	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/28/2015**

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GOOD SAMARITAN SOCIETY - WINTHROP	**506 HIGH STREET** **WINTHROP, MN 55396**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 28th, 2015. At the time of this survey, Building 01 of Good Samaritan Society Winthrop was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

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

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	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/28/2015**

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Good Samaritan Society Winthrop is a one-story building with partial basement. The original building was constructed 1965, with building additions constructed in 1966, 1994 and 1995. All buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 28 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 018		9/7/15

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K 018	Continued From page 2 hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had a corridor door that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.6. This deficient practice could affect the safety of 15 of 28 residents, staff and visitors, if smoke were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:00 AM and 2:00 PM on 07/28/2015, it was observed that the corridor door for resident rooms 109 and 111 did not fit tightly into the frame and would not positively latch into the frame.	K 018	K018- The doors for room 109 and 111 will be fixed by the facility to fit tightly into the frame and positively latch. The ENS supervisor or designee will monitor for compliance Date of completion 09/07/2015	

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K 018	Continued From page 3 This deficient practice was verified by the Director of Environmental Services (SS).	K 018		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for several corridor smoke barrier doors throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.6.3.1., and NFPA 80 Fire Doors and Fire Windows (99) The following deficient practice could negatively affect the patients, staff, and visitors as smoke could migrate between smoke barriers making the corridor untenable. Findings include: On facility tour between 10;00 AM and 2:00 PM on 07/28/2015, observation revealed: 1. Fire doors near administration would close when tested and could not be verified that they are fire rated doors.	K 027	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	10/3/15

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	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/28/2015**

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K 027	Continued From page 4 2. Fire doors near room 127 would not close when tested. This deficient practice was verified by the Director of Environmental Services (SS).	K 027		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 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 by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 28 residents. Findings include: On facility tour between 10:00 AM and 2:00PM on 07/28/2015, the review of the fire drills reports for 07/2014-07/2015, the following drill was missed: 1. 4th quarter Night shift.	K 050	K50- The facility has ensured that all fire drills are being done monthly with rotating the shift and times each month. The ENS supervisor/designee will monitor for compliance. Date of completion 09/07/2015	9/7/15

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K 050	Continued From page 5 This deficient practice was verified by the Director of Environmental Services (SS).	K 050		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all 28 residents, visitors, and staff. 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).	K 054	K054- The facility will have the company responsible 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 Date of Completion 09/07/2015	9/7/15
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		9/7/15

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K 056	Continued From page 6 installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 07/28/2015, observations revealed the following deficient conditions were found affecting the facility's fire sprinkler system: 1. There are corroded/painted sprinkler heads in the kitchen and dining area. 2. Room 117, the family lounge has 2 sprinkler	K 056	K056- The facility will have the company who installed the sprinkler heads clean and/or replace the corroded and painted sprinkler heads in the kitchen and dining room. The facility will have the same company who installed the sprinkler heads remove one of the two sprinkler heads that are only 1 ¿ feet apart in the family lounge. The ENS supervisor will monitor for compliance Date of completion 09/07/2015	

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K 056	Continued From page 7 heads 1 1/2 feet apart. This deficient practice was verified by the Director of Environmental Services (SS).	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 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 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). 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 have negatively affect all residents, staff and visitors. Findings include: On facility tour between 10:00 AM and 2:00 PM on 07/28/2015, a review of documentation and interview with the Director of Environmental Services (SS), revealed the facility failed to complete their annual fire sprinkler test as required by NFPA 13(99) and NFPA 25(98). The	K 062	K062- The facility has completed the annual sprinkler test on 01/29/2015 The ENS supervisor/designee will monitor for compliance Date of compliance 09/07/2015	9/7/15

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K 062	Continued From page 8 previous sprinkler testing was done on September 12th, 2013 and last fire sprinkler annual test/inspection was conducted on January 29th, 2015 resulting in more than a year between inspection and maintaining their system. This deficient practice was verified by the Director of Environmental Services (SS).	K 062		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it could not be verified whether the facility's general ventilating and air conditioning system (HVAC) was maintained in accordance with NFPA 101 (2000) Chapter 19, Section 19.5.2.1 and Chapter 9, Section 9.1 and NFPA 90A [1999]. In a fire emergency, a noncompliant HVAC system could adversely affect all residents, staff and visitors. FINDINGS INCLUDE: On 07/28/2015 at 10:00AM, during an interview with facility staff, it was confirmed the HVAC system does contain one or more fire/smoke dampers, however, no documentation could be provided verifying the fire/smoke dampers were inspected and tested within the previous 4 years,	K 067	K067- The facility will have the HVAC system that contains fire/smoke dampers to be inspected and tested by the company that maintains our fire/smoke dampers. The ENS supervisor will monitor for compliance. Date of completion 09/07/2015	9/7/15

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K 067	Continued From page 9 in accordance with NFPA 90A [1999] Chapter 3, Section 3-4.7. This deficient practice was verified by the Director of Environmental Services (SS)..	K 067		
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on a review of documentation and an interview with staff, it was determined that the kitchen hood suppression system is not in accordance with NFPA 101 The Life Safety Code (edition 2000), Section 19.3.2.6 and NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operation (edition 1998) section 1-3.1. This deficient practice could negatively affect any residents, any visitors and the staff in the kitchen area. Findings Include: During the facility tour at approximately 10:00 AM, on 07/28/2015, observations revealed that the maintenance on the hood suppression system was last completed in September 16, 2014. This deficient practice was verified by the Director of Environmental Services (SS)..	K 069	K069- The facility had the maintenance of the hood suppression system completed on 03/16/2015 The ENS supervisor will monitor for compliance Date of completion 09/07/2015	9/7/15

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	245314	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**07/28/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 28, 2015. At the time of this survey, Building 02 of Good Samaritan Society Winthrop was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 08/22/2015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**07/28/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINTHROP	**506 HIGH STREET WINTHROP, MN 55396**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 02 of Good Samaritan Society Winthrop consists of a six-bed resident room addition, constructed in 2006. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. All resident rooms in Building 02 are equipped with automatic smoke detection. The facility has a capacity of 37 beds and had a census of 28 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching	K 018		9/7/15

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K 018	Continued From page 2 hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain one or more corridor doors in the means of egress in accordance with the requirements at NFPA 101 (2000) Chapter 18, Section 18.3.6.3. This deficient practice could adversely affect 10 of 28 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 07/28/2015, it was observed that the corridor door for resident rooms 133 and 134 did not fit tightly into the frame and would not positively latch into the frame. This deficient practice was verified by the Director of Environmental Services (SS).	K 018	K018- The doors for room 133 and 134 will be fixed to fit tightly into the frame and positively latch. The ENS supervisor or designee will monitor for compliance Date of completion 09/07/2015	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by:	K 029		9/7/15

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K 029	Continued From page 3 Based on observation, the facility failed to maintain a hazardous area door in accordance with NFPA 101 (00), Chapter 19, Section 19.3.2.1 and 19.3.6.3.2, and Chapter 8, Section 8.2.3.2.3.2. In a fire emergency, this deficient practice could adversely affect 10 of 28 residents, staff and visitors. FINDINGS INCLUDE: During facility tour between 10:00 AM and 2:00 PM on 07/28/2015, observation revealed that the Beauty Shop had excessive storage in it that could consider it to be a hazardous storage room. The items in this room included hoyer lifts, soiled linen bins (3). The door is not equipped with a self-closure device. This deficient practice was verified by the Director of Environmental Services (SS).	K 029	K029- The hoyer lifts and the soiled linen bins have been removed from beauty shop.The staff will all be educated on what things can be stored in the beauty shop. The ENS supervisor/designee will monitor for compliance Date of completion 09/07/2015	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by:	K 050	K50- The facility has ensured that all fire drills are being done monthly with rotating	9/7/15

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K 050	Continued From page 4 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 last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:00 AM and 2:00PM on 07/28/2015, the review of the fire drills reports for 07/2014-07/2015, the following drill was missed: 1. 4th quarter Night shift. This deficient practice was verified by the Director of Environmental Services (SS).	K 050	the shift and times each month. The ENS supervisor/designee will monitor for compliance. Date of completion 09/07/2015	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), The deficient practice could affect all residents..	K 054	K054- The facility will have the company responsible 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 Date of Completion 09/07/2015	9/7/15

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K 054	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).	K 054		
K 062 SS=F	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. Findings include: On facility tour between 10:00 AM and 2:00 PM	K 062	K062- The facility has completed the annual sprinkler test on 01/29/2015 The ENS supervisor/designee will monitor for compliance Date of compliance 09/07/2015	9/7/15

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K 062	Continued From page 6 on 07/28/2015, a review of documentation and interview with the Director of Environmental Services (SS), revealed the facility failed to complete their annual fire sprinkler test as required by NFPA 13(99) and NFPA 25(98). The previous sprinkler testing was done on September 12th, 2013 and last fire sprinkler annual test/inspection was conducted on January 29th, 2015 resulting in more than a year between inspection and maintaining their system. This deficient practice was verified by the Director of Environmental Services (SS).	K 062		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include:	K 067	K067- The facility will have the HVAC system that contains fire/smoke dampers to be inspected and tested by the company that maintains our fire/smoke dampers. The ENS supervisor will monitor for compliance. Date of completion 09/07/2015	9/7/15

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K 067	Continued From page 7 On 07/28/2015 at 10:00AM, during an interview with facility staff, it was confirmed the HVAC system does contain one or more fire/smoke dampers, however, no documentation could be provided verifying the fire/smoke dampers were inspected and tested within the previous 4 years, in accordance with NFPA 90A [1999] Chapter 3, Section 3-4.7. This deficient practice was verified by the Director of Environmental Services (SS)..	K 067		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00961	A. BUILDING: _____ B. WING _____	07/30/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On July 27th to July 30th 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000		

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2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was followed for 1 of 3 residents (R10) reviewed for non-pressure skin concerns. Findings included: R10's care plan dated 5/24/15, directed staff R10 was prescribed an anticoagulant (blood thinning medication known to contribute to bruising). Interventions included monitoring for bruising. R10 was observed to have 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 nursing (CDON) with the surveyor looked at R10's arms. The CDON verified the presence of bruising and skin tears on the resident's arms. On 7/29/15, at 9:14 a.m. the CDON reviewed	2 565	Corrected	9/7/15

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2 565	Continued From page 2	2 565		

progress notes from 7/1/15 and verified there was no documentation related to R10's skin issues. The DON stated it was expected the NAs would report any skin changes to the charge nurse.

At 9:26 a.m. the CDON asked a licensed practical nurse (LPN)-A if she noticed the bruising on the left forearm or if R10 had been found on his left side when he recently fell. LPN-A replied, "No. The only thing we had noticed was after the fall were the skin tears on the right arm and by the elbow and he was found on his right side." When LPN-A was asked by CDON if she had received any report of injuries LPN-A denied receipt of any reports.

A nursing assistant (NA)-A then reported at 9:40 a.m. R10 had experienced a fall recently, which she thought caused the bruises and skin tears. NA-A explained that the NAs were supposed to report any changes in skin conditions, but thought it had been reported and investigated, as the bruising had been present on R10's arm since Monday.

SUGGESTED METHOD OF CORRECTION:

The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 565	Continued From page 3 (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and 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 evidenced by: Based on observation, interview and document review, the facility failed to identify non-pressure related skin conditions for 1 of 3 residents (R10) with observed bruising and failed to ensure the continuous positive airway pressure (C-PAP breathing machine providing air for sleep apnea) machine and mask were cleaned for 1 of 1 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	2 830	Corrected	9/7/15

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2 830	Continued From page 4 nursing (CDON) with the surveyor looked at R10's arms. The CDON verified the presence of bruising and skin tears on the resident's arms. R10's care plan dated 5/24/15, indicated the resident was prescribed an anticoagulant (blood thinning medication known to contribute to bruising). Interventions included monitoring for bruising. R10's 6/2/15, quarterly Minimum Data Set (MDS) indicated the resident had severely impaired cognition. Progress Notes dated 7/1/15 though 7/29/15, revealed no documentation related to alterations in the resident's arms. On 7/29/15, at 9:14 a.m. the CDON reviewed progress notes from 7/1/15 and verified there was no documentation related to R10's skin issues. The DON stated it was expected the NAs would report any skin changes to the charge nurse. At 9:26 a.m. the CDON asked a licensed practical nurse (LPN)-A if she noticed the bruising on the left forearm or if R10 had been found on his left side when he recently fell. LPN-A replied, "No. The only thing we had noticed was after the fall were the skin tears on the right arm and by the elbow and he was found on his right side." When LPN-A was asked by CDON if she had received any report of injuries LPN-A denied receipt of any reports. A nursing assistant (NA)-A then reported at 9:40 a.m. R10 had experienced a fall recently, which she thought caused the bruises and skin tears. NA-A explained that the NAs were supposed to report any changes in skin conditions, but thought it had been reported and investigated, as the bruising had been present on R10's arm since Monday.	2 830		

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GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 After the concern was brought to the staffs' attention, an incident report dated 7/29/15, noted the presence of a bruise on R10's left forearm measuring 4.5 x 3.0 centimeters (cm). A 5/15, Skin Assessment, Pressure Ulcer Prevention And Documentation Requirements policy under Assessment and Documentation of Bruises/Contusions/Skin tears/Abrasions read: "If a bruise, contusion, abrasion or skin tear is observed on a resident, this should be reported to the nurse immediately...The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation UDA [unknown acronym] and on the resident's care plan...." R5's room was observed on 7/28/15, at 10:08 a.m. A C-PAP machine and the long tubing attached to the nose piece was stored on top of a bedside adjacent to R5's bed. The mask had a creamy white/brown build up in the inside of the mask and around the seams. On 7/29/15, at 8:20 a.m. C-PAP nasal piece mask continued to have a thick creamy/brown build up on the inside and the seams. R5 had a physician's order dated 10/13/11, directing "C-PAP at night one time a day related to obstructive sleep apnea." A psychopharmacological medication and antidepressant medication care plan dated 4/10/14, directed staff to provide sleep encouragement techniques which included applying the C-PAP machine mask at bedtime. In addition, direction was provided to staff to clean the C-PAP weekly.	2 830		

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2 830	Continued From page 6 A 7/29/15, Admission Record revealed R5 had diagnoses including obstructive sleep apnea (complete or partial blockage of upper airway during sleep), insomnia (inability to fall asleep or stay asleep and narcolepsy (poor control of sleep wake cycles). A nursing assistant (NA)-C explained on 7/29/15, at 9:19 a.m. that the cleaning of R5's C-PAP machine involved, "General care--rinse out and leave to dry." NA-C was unsure of the facility policy regarding cleaning of C-PAP machines. At 9:27 a.m. the consultant director of nursing (CDON) then verified debris in R15's C-PAP mask and acknowledged it was not clean. Later, at 10:15 a.m. the CDON reported, "I doubt we have a policy for CPAP cleaning. It says to follow the manufacturer's instructions." A 9/12 C-PAP Therapy policy directed staff to "Please refer to the manufacturer's instructions." The manufacturer Phillips Respironics 2014 instructions indicated masks should have been cleaned daily and headgear at least weekly in warm soapy water. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies/procedures, train staff and monitor to assure residents and their equipment are appropriately monitored. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		9/7/15

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21530	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure monthly medication reviews were completed for 1 of 5 residents (R30) reviewed for unnecessary medications. Findings include: On 7/29/15, at 9:30 a.m. R30 was observed sleeping in his room. Nursing assistant (NA)-C stated R30 always sleeps in until 10:00 a.m. when they get him up for the day. R30 was admitted to the facility on 1/9/14, with diagnoses including cerebrovascular disease, dementia, and major depressive disorder. Care plan dated 7/31/14, indicated R30 received an antidepressant related to potential for alteration in mood related to diagnosis of depressive disorder evidenced by periods of flat affect, not talking to others. A review of the consultant pharmacist monthly record of drug regimen review indicated reports were not completed for October 2014, December 2014, January 2015, April 2015, June 2015, and July 2015. The Physician Orders dated 7/6/15, indicated R30 received Celexa (anti-depressant) 20 milligram (mg) once daily. The Care Area Assessment (CAA) analysis dated 7/30/15, indicated R30 was on antidepressant medication with treatable medical condition such	21530	Corrected	

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21530	Continued From page 9 as cerebrovascular accident and had disturbances of balance, gait, positioning ability. On 7/30/15, at 8:30 a.m. consultant pharmacist (CP) stated she would look for monthly medication reviews and call or fax the information. Monthly medication reviews were not provided. On 7/30/15, at 10:10 a.m. the consultant director of nursing (CDON) stated if monthly medication reviews were completed, the facility would have them filed. The unnecessary medications policy dated September 2012, indicated: ..."pharmacy, the center and consultant pharmacist are responsible for identifying orders from multiple prescriber's and assist in determining the use of unnecessary medications." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could ensure monthly medication reviews were completed. Nursing staff could be educated as necessary to the importance of the pharmacist's review and monitor to assure reviews were completed. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		

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21670	Continued From page 10	21670		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clean and sanitary bed linens were provided as needed for 1 of 1 resident (R5) reviewed for activites of daily living. Findings included: On 7/28/15, at 10:08 a.m. during R5's room observations the fitted sheet was noted to have a large brown smear, by the right grab bar.	21670	Corrected	9/7/15

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21670	Continued From page 11 On 7/29/15 at 7:20 a.m. R5 was observed to be wheeled to the dining room in a wheelchair. After the meal, at 8:20 a.m., with staff assistance R5 was transferred back to her room and assisted into the recliner chair. During this observation, the fitted sheet on R5's bed was still soiled with a large brown smear, up near the bed rail. On 7/29/15, at 9:22 a.m. licensed practical nurse (LPN)-B, during a subsequent tour to the room, verified the brown smear on bedsheet near the grab bar. LPN-B explained that even though it was not R5's bath day, the linen should have been changed. LPN-B stated she would have the nursing assistant change it. During interview, at 9:27 a.m., the consultant director of nursing (CDON) commented that the brown smear on the sheet appeared to be fecal matter and stated the bed sheet should have been changed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies/procedures, provide staff training and monitor to assure bed linens are clean for the residents use. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21670		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services	21695		9/7/15

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21695	Continued From page 12 necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and sanitary environment was maintained, which had the potential to affect 3 of 28 residents (R14, R5, R4) who resided in resident rooms observed during the environmental tour. Findings include: During an environmental tour on 7/29/15, at 1:31 p.m., with the environmental services supervisor (ESS), the following environmental concerns were noted and verified: On 7/28/15, R14's toilet seat, behind risers, was observed to be stained and an odor was detected. During the tour ESS verified the stain and the need for cleaning. ESS stated staff would clean it and if the stain did not come off, the toilet seat would be replaced. On 7/28/15, R5's bathroom was observed to have a strong odor in the shared bathroom. During the tour ESS explained that R5's roommate (R4) used a lot of toilet paper and used the bathroom garbage for the toilet paper, instead of the toilet. ESS also stated that R5 throws the incontinent pad in the garbage and if staff doesn't empty the garbage, the bathroom has an odor. On 7/29/15, ESS identified that the maintenance clipboard, located at the nurse's station, was for	21695	Corrected	

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21695	Continued From page 13 staff to write environmental concerns. ESS also stated the cleaning schedule for cleaning all rooms and toilets was daily. On 7/30/15, at 9:08 a.m. when interviewed, nursing assistant (NA)-B stated if she had an environmental concern, she would notify environmental services. If unavailable, she would notify the charge nurse. If neither were available, she would write the concern on the maintenance clipboard. At 9:17 a.m., when interviewed, the licensed practical nurse (LPN)-B stated if she had an environmental concern she would write it on the clipboard or if necessary, would call them. The facility cleaning of common areas policy dated December 2008, revised 6/14, indicated: ..."3. All parts of the community will be kept clean, neat and free of litter. 7. Clean surfaces as often as necessary to keep furniture and equipment free of accumulations of dust, dirt, food particles, etc. 15. Empty bathroom wastebaskets daily or as needed. Disinfect as needed." SUGGESTED METHOD OF CORRECTION: The director of nursing, maintanence, housekeeping or designee could assure that bathroom toilets are in working order, clean and that bathrooms are odor free. Policy and procedures could be reviewed and staff trained to assure appropriate departments are notified. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and	21810		9/7/15

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21810	Continued From page 14 residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a call light was within reach for 1 of 1 resident (R46) whose call light was out of reach during a specialized treatment. Findings include: On 7/28/15 at 9:55 a.m., R46 was observed to be awake sitting up in his recliner, with arterial pumps on both legs. The call light cord was hanging on R46's grab bar and not within reach should the resident have needed assistance from staff. A licensed practical nurse (LPN)-A entered the room and the resident's call light position was pointed out to the LPN. LPN-A stated, "No, it is not within reach" and moved it to the recliner armrest. LPN-A stated the call light should have been within the resident's reach, and R46 stated he could then reach and use the call light. R46's admission Minimum Data Set dated 6/9/15, indicated R46 had moderately impaired cognition. The corresponding Care Area Assessment (CAA) analysis dated 6/14/15, revealed R46 required assistance with activities of daily living (ADLs) including bed mobility, dressing, toileting and personal hygiene. The CAA indicated resident	21810	Corrected	

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21810	Continued From page 15 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. On 7/28/15, at 9:55 a.m. LPN-A stated when resident had arterial pumps on his legs he should use call light for assistance. On 7/28/15, at 10:59 a.m. when asked the consultant director of nursing (CDON) stated when resident was in his room, the call light should have been within reach whether R46 was in bed or in the chair. A 9/12, Call Light procedure directed staff, "When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure that policy and procedures are up to date, that staff are trained and that call lights are monitored to assure they are in reach and accessible to the residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		