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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3JL4

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 **8/18/2016** (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 **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(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 : 08/26/2016
Carrie Euerle, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 8/26/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245314

August 26, 2016

Mrs. Teresa Hildebrandt, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

Dear Mrs. Hildebrandt:

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 August 12, 2016 the above facility is certified for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 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
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 26, 2016

Mrs. Teresa Hildebrandt, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

RE: Project Number Project Number S5314025 and Complaint number H5314005

Dear Mrs. Hildebrandt:

On July 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 8, 2016 that included an investigation of complaint number H5314005. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On August 18, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 8, 2016, effective August 12, 2016 and therefore remedies outlined in our letter to you dated July 26, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245314 Y1	A. Building B. Wing Y2	8/18/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	08/12/2016	LSC	08/12/2016	LSC	08/12/2016
ID Prefix F0314	Correction	ID Prefix F0328	Correction	ID Prefix F0329	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(k)	Completed	Reg. # 483.25(l)	Completed
LSC	08/12/2016	LSC	08/12/2016	LSC	08/12/2016
ID Prefix F0425	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.60(a),(b)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	08/12/2016	LSC	08/12/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	8/26/2016	31591	8/18/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/8/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245314 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/24/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	08/08/2016	LSC K0029	08/08/2016	LSC K0038	08/08/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	08/12/2016	LSC K0062	08/12/2016	LSC K0064	08/08/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0144	08/08/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	8/26/2016	34764	8/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/6/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245314 Y1	A. Building 02 - 2006 ADDITION B. Wing Y2	8/24/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	08/12/2016	LSC K0062	08/08/2016	LSC K0064	08/02/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0144	08/08/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL /kfd	8/26/2016	34764	8/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/6/2016

☐ 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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3JL4

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 **07/08/2016** (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 **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(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 : 08/05/2016 (L19)
Lou Anne Page, HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date: 08/19/2016 (L20)
Kamala Fiske-Downing, Health Program Representative

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 Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 26, 2016

Mrs. Teresa Hildebrandt, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

RE: Project Number S5314025 and complaint number H5314005

Dear Mrs. Hildebrandt:

On July 8, 2016, 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. In addition, at the time of the July 8, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5314005.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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:

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

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

Remedies - 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;

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

Informal Dispute Resolution - 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 August 17, 2016, 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 August 17, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (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. 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 will be conducted to verify that

substantial compliance with the regulations has been attained. The revisit 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 8, 2016 (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 8, 2017 (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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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 _____	07/08/2016

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. An investigation of complaint, H5314005 was completed. The complaint was substantiated. Deficiency (ies) were issued at F282 and F328.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280		8/12/16

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

Electronically Signed | 08/04/2016

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 _____	07/08/2016

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 280	Continued From page 1 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the comprehensive care plan to include interventions for pain management for 1 of 1 resident (R11) assessed to have pain with daily dressing changes. Findings include: R11's wound care was observed on 7/7/16, at 9:43 a.m., licensed practical nurse (LPN)-A completed a dressing change to R11's wound on her toes. While LPN-A was applying the anti-embolism hose to her left foot R11 visibly flinched. During an observation on 7/8/16, at 1:33 p.m. the director of nursing (DON) was observed completing a wound treatment to R11 left toes. When R11's sock was removed she moaned, "Ohhhhhh," and grimaced. As the DON separated her toes to assess the wound, R11 again began moaning, "Oh, oh" and grimacing. The DON asked R11 how her toes were and R11 stated, "It hurts" and rated her pain "about a 7-8/10." The DON asked if Tylenol (a mild anlagesic) would help with the pain and R11 stated Tylenol did help. R11's care plan dated 1/2/16, indicated a potential for chronic pain related to osteoarthritis, exhibited by verbal reports of pain. The care plan	F 280	General Disclaimer Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F-280 R11□s has had a new pain assessment completed and care plan updated to reflect those findings. Physician was notified of findings and pain	

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 _____	07/08/2016

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 280	Continued From page 2 indicated R11 was able to call for assistance when in pain, could ask for medication, and directed staff to observe for and report any symptoms of pain. Although the care plan indicated R11 was able to report pain and request medication, a Good Samaritan Society Pain Assessment dated 3/22/16, indicated R11's current pain regimen was not working and indicated she had Tylenol scheduled and as needed, but "will not ask for it." The care plan did not address pain during treatments. R11's quarterly Minimum Data Set (MDS) dated 6/14/16, indicated she was cognitively intact, required extensive to total assist with all activities of daily living and had a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The MDS further indicated R11 was not receiving pain medication, but reported occasional pain rated 8/10 which made it hard for her to sleep at night and limited her physical activity. A previous MDS dated 3/22/16, indicated R11 was receiving scheduled pain medication and reported occasional pain rated 5/10 that interfered with sleep but did not limit her physical activity. A Good Samaritan Society Pain Assessment dated 6/14/16, indicated R11 had orders for Tylenol and Ultram (a narcotic) as needed and indicated the current regimen was working, even though R11's MDS dated the same day indicated her pain had worsened since the previous assessment and she had not received any medication for pain. A Good Samaritan Society Wound RN (registered	F 280	medications have been adjusted. On-going monitoring and assessment for effectiveness of pharmacological and non-pharmacological interventions will occur. All current residents have had new pain assessments completed by 7-29-16. Those residents identified will have care plans updated, record review completed, and physician notified if change is needed. On-going monitoring of acceptable use of pharmacological and non-pharmacological interventions will occur. Licensed staff will be trained on pain assessment both verbal and nonverbal, pain data collection tool by 8-12-16. Non-licensed staff will be trained by 8-12-16 on verbal and nonverbal signs of pain and when to report to the licensed nurse. Five Observation audits of verbal and nonverbal pain management will be conducted weekly for 4 weeks and then bi- monthly for 1 month and monthly X2 by the Director or Nursing Services or designee. Record review audits of medication administration records, pain data collection tools and pain assessment will be done weekly X4, bi-monthly X 1 and then monthly X 2 for residents identified as having pain and the effectiveness of interventions. Audit results will be reviewed by QAPI committee for further recommendation.	

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 _____	07/08/2016

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 280	Continued From page 3 nurse) Assessment dated 7/6/16, indicated R11 had a pressure ulcer located on her toe. During an interview on 7/6/16, at 8:39 a.m., R11 stated her feet hurt. She stated the nurse had changed the dressing to her foot and stated, "Now it will hurt almost until dinner time." During a subsequent interview on 7/7/16, at 1:04 p.m., R11 stated her toes were hurting. She stated she doesn't tell anyone when her feet hurt and stated no one asks her about pain. R11 stated her feet hurt every day and rated the pain at 8/10 on average. She stated she had trouble sleeping because of the pain and stated when she received Tylenol it helped with the pain. During an interview on 7/7/16, at 1:09 p.m., LPN-A stated she was aware R11 did not complain when she had pain. During an interview on 7/7/16, at 1:48 p.m., the DON stated if there was an increase in a resident's level of pain she would expect the physician to be notified and would expect staff to monitor the resident for pain every shift. The DON further stated the RN should be evaluating each assessment, looking for changes and implementing interventions when needed. During an interview on 7/8/16, at 9:52 a.m. LPN-B stated R11 received a treatment to her foot every day and stated, "She does have pain during the treatment." While R11 had an increase in her pain level that was affecting her ability to sleep and her daily functioning and had pressure ulcers on her toes which caused her pain during treatments, no pain interventions were implemented, according to the plan of care, prior to her dressing changes.	F 280	Completion date: 8-12-16	

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 _____	07/08/2016

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 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 the care plan was followed for ongoing assessment according for 1 of 1 resident (R55) reviewed for worsening respiratory status. In addition, the facility failed to ensure 1 of 3 residents were repositioned according to the plan of care (R23). Findings include: R55's Admission Record indicated R55 had been admitted to the facility on 10/23/15. According to the Admission Record, R55's admission diagnoses included: acute respiratory failure and congestive heart failure (CHF). The Hospital Discharge Orders included oxygen via nasal cannula to keep oxygen saturation levels equal to 90% and BIPAP at night (BIPAP refers to the use of a breathing apparatus that helps the user get more air into his/her lungs and is useful in aiding with sleep apnea) and daily weights due to CHF. R55's care plan dated 10/24/15, identified a problem area of congestive heart failure exhibited by the need for oxygen therapy, and limited physical mobility related to respiratory failure. Care plan interventions directed staff to weigh R55 every morning, monitor for labored breathing, apply oxygen, and to ensure R55 used	F 282	F-282 R-55 is no longer a resident at this facility. R-23 No longer has pressure area. Resident□s care plan updated to reflect the current needs of the resident. Nursing staff are implementing the appropriate plan of care. Facility has since contracted with a new Oxygen provider who has better response time for equipment needs. All current residents with a Braden scale showing them at risk will have a positioning data tool completed 08/12/2016. The findings from the tool will be updated to the care plan. Licensed staff to be re-educated on policy and procedure related to respiratory monitoring and ensuring proper equipment is available and operational on 08/02/2016. Nursing staff will be re-educated on the reporting of new skin issues and interventions to prevent skin breakdown and updating care plans on 08/02/2016. Observation audits of respiratory assessments will be completed on 3 residents weekly X 4, monthly X 2. Record review audits of new admissions and residents with acute respiratory symptoms, wound data collection tool,	8/12/16

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 _____	07/08/2016

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 282	Continued From page 5 the BIPAP machine at night and during naps. The resident's nursing progress notes indicated the following: On 10/23/15, R55 admitted to the facility. His CPAP [BIPAP] machine was unusable upon admission. Allina Home Oxygen was contacted and would bring out new supplies on Monday (10/26/15). A subsequent progress noted dated 10/23/15, indicated R55 displayed shortness of breath, received a nebulizer treatment, and was receiving oxygen via nasal cannula. The progress note did not indicate R55's oxygen saturation levels. Another progress note dated 10/25/15, indicated R55's oxygen saturation level had measured 80%. R55 was sent to the hospital and did not return to the facility. While R55 had been in the facility from 10/23/15 to 10/25/15, there was no evidence of ongoing oxygen saturation monitoring. Aside from the progress note dated 10/25/15, A Good Samaritan Society - Winthrop Weights and Vitals Summary indicated oxygen saturation levels were assessed only one other time, on 10/24/16, at 6:20 p.m. A Good Samaritan Society Discharge Summary dated 11/2/15, indicated R55 discharged from the facility on 10/25/15, at 6:28 p.m. The hospital discharge summary dated 11/1/15, indicated R55 had presented to the hospital from Good Samaritan Society Winthrop with shortness of breath and hypoxia (hypoxia indicates there is not enough oxygen reaching the body's tissue). The discharge summary further indicated R55 was found to have fluid overload as well as "untreated sleep apnea (had not been using his BIPAP)." R55's Medication Administration Record (MAR) dated October 2015, indicated R55's BIPAP	F 282	and RN Wound Assessments, and care plans and positioning data tools will be completed weekly x 4 weeks, then monthly x 2. Audit results will be reviewed by QAPI committee for further recommendation. Completion Date: 8-12-16	

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 _____	07/08/2016

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 282	Continued From page 6	F 282		

machine had been prescribed but not used while at the facility. In addition, an order for DuoNeb (breathing medication) solution every four hours as needed for shortness of breath was in place, however R55 had not received the DuoNeb on 10/25/15, when the progress notes described him as short of breath. The MAR did not include the order for oxygen, nor was there evidence of monitoring oxygen saturation levels.

During an interview on 7/7/16, at 1:46 p.m., licensed practical nurse (LPN)-A stated she was working the day R55 was sent to the hospital but could not remember why he had been sent in.

During an interview on 7/8/16, at 11:23 a.m., family member (F)-A stated she had visited R55 on Friday and Saturday. She stated when she visited on Sunday R55 was gray in color and he was having difficulty breathing. FM-A stated she'd gone to find a nurse but stated it took a while. FM-A stated when she found the RN, the registered nurse (RN) gave her the oximeter and asked her to check R55's oxygen levels. FM-A stated when she checked R55 his oxygen saturation level was at 68%.

During an interview on 7/8/16, at 11:35 a.m., the administrator stated R55 had been a resident prior to when she (the administrator) had started at the facility, but that she'd done some research regarding this issue. The administrator verified R55 had been admitted to the hospital with acute respiratory failure and hypoxia and had not returned to the facility after hospitalization.

During an interview on 7/8/16 at 12:19 p.m., the director of Nursing (DON) confirmed R55 had been admitted with respiratory failure and should

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 _____	07/08/2016

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 282	Continued From page 7	F 282		

have been monitored for respiratory status including oxygen saturation levels, lung sounds and respirations each shift. The DON further stated when the facility learned that R55's BIPAP machine was not useable, the facility should have made arrangements to have a new machine delivered immediately to the facility. In addition, the DON said since R55 did not have the BIPAP as ordered during his stay at the facility, she would have expected additional monitoring. The DON indicated the facility had not had any other resident admitted to the facility that had a BIPAP machine. In addition, there were no others residents in the facility at the time of survey with oxygen.

R23 was observed sitting up in Broda chair watching television (TV) in the day room. No cushion in chair on 7/6/16, at 3:56 p.m. On 7/6/16, at 4:03 p.m. R23 was sitting in day room watching TV. R23 said Broda chair was new. R23 said, "It is not comfortable."

During frequent observations on 7/7/16, from 7:52 a.m. to 10:05 a.m. and the following was observed:
-7:52 a.m. R23 sitting in Broda chair in room. NA-B was shaving R23.
-8:21 a.m. R23 sitting in day room in Broda chair watching TV.
-9:03 a.m. R23 remains sitting in same position.
-9:48 a.m. R23 same position watching TV.
-10:05 a.m. R23 in same position watching TV.

R23's significant change Minimum Data Set (MDS) dated 5/9/16, indicated R23 was severely cognitive impaired and required assistance with bed mobility, transfers, eating and toileting. R23's

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 _____	07/08/2016

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 282	Continued From page 8	F 282		

MDS indicated R23's diagnoses included dementia, and arthritis. MDS indicated R23 was at risk for pressure ulcer development, with pressure reducing device for chair and bed and turning and repositioning program.

Pressure Ulcer Care Area Assessment dated 5/11/16, indicated R23 required specialty mattress or seat cushion to relieve pressure and regular schedule of turning and repositioning.

Wound Data Collection dated 7/3/16, indicated R23 had a stage two pressure ulcer on right buttock, measuring 0.25 cm. x 0.25 cm. The section for modification to interventions was blank form did indicate that physician was notified of pressure ulcer.

Care plan printed 7/18/16, instructed staff that R23 had potential impairment to skin as revised on 12/9/14, and instructed staff resident needs pressure reducing mattress to protect skin in bed, Broda chair and to elevate heels while in bed. The Care Plan did not address turning, repositioning or history of frequent pressure ulcer development.

During interview on 7/8/16, at 9:58 a.m. the DON said was they unaware R23 had a pressure ulcer. The DON stated pressure ulcers should be care planned immediately. DON said, "About a week ago his cushion started leaking so we are getting a new cushion, but it is not here." The DON said R23 has a history of pressure ulcers opening and closing. The DON said I would expect them to reposition him every two hours when in the chair. The DON said I would expect him to have a care plan for recurrent pressure ulcer.

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 _____	07/08/2016

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 309	Continued From page 9	F 309		
F 309 SS=G	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 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 ensure 1 of 3 (R11) residents was free from pain during a dressing change. R11 sustained harm as the resident was in pain during the wound care process and was not pre-medicated for pain. The treatment needed to be stopped by the surveyor. In addition, the facility failed to ensure 1 of 1 resident (R17) skin was assessed for non-pressure related skin breakdown in order to determine an appropriate plan for care. Findings include: R11's Care Area Assessment (CAA) dated 12/29/15, indicated pain as a potentially reversible problem affecting R11's function. R11's care plan dated 1/2/16, indicated a potential for chronic pain related to osteoarthritis, exhibited by verbal reports of pain. The care plan indicated R11 was able to call for assistance when in pain, could ask for medication, and directed staff to observe for and report any symptoms of pain. Although the care plan	F 309	F-309 R11□s has had a new pain assessment completed and care plan updated to reflect those findings. Physician was notified of findings and pain medications have been adjusted. On-going monitoring and assessment for effectiveness of pharmacological and non-pharmacological interventions will occur. R11 had appointment with vascular physician 7-28-16 who diagnosed her with arterial ulcers on left third, fourth and fifth digits. Record was updated to reflect the new diagnosis. R17 has had a new skin observation tool, positioning assessment and evaluation tool, and care plan updated. All current residents have had a new pain assessment completed by 7-29-16. Those residents identified will have care plans updated, record review completed, and physician notified if change is needed. On-going monitoring of acceptable use of pharmacological and	8/12/16

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 _____	07/08/2016

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 309	Continued From page 10 indicated R11 was able to report pain and request medication, a Good Samaritan Society Pain Assessment dated 3/22/16, indicated R11's current pain regimen was not working and indicated she had Tylenol (a mild analgesic) routinely scheduled and as needed, but "will not ask for it." R11's Minimum Data Set (MDS) dated 3/22/16, indicated R11 was receiving scheduled pain medication and reported occasional pain rated 5/10 that interfered with sleep but did not limit her physical activity. The quarterly MDS dated 6/14/16, indicated R11 was cognitively intact, required extensive to total assist with all activities of daily living and had a stage II pressure ulcer (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The MDS further indicated R11 was not receiving pain medication, but reported occasional pain rated 8/10 which made it hard for her to sleep at night and limited her physical activity. Although the 6/14/16, MDS identified R11 had occasional pain and there was no scheduled pain regimen, no as needed pain medication and no non-pharmacological pain interventions the care plan showed no evidence of change. A Good Samaritan Society Pain Assessment dated 6/14/16, indicated R11 had orders for Tylenol and Ultram (a narcotic) as needed and indicated the current regimen was working, even though R11's MDS dated the same day indicated her pain had worsened since the previous assessment and she had not received any medication for pain. Between 6/7/16 and 7/6/16 there were 16 Wound	F 309	non-pharmacological interventions will occur. Reviewing skin observation tool and positioning assessment tools on all residents for findings and updating care plans to reflect current needs. Nursing staff were educated on wound measurements and staging of wounds on 7-18-16 by AMT Consulting Wound Nurse. Nursing staff will also be re-educated on the Wound Data Collection tool and RN Wound Assessment and their usage 8-2-16. Nursing staff were also educated on notification of new skin issues to physicians for change in treatment/follow up on 8-2-16. Record review on wound data collection tools and RN Wound Assessment will be completed x 4 weeks then monthly x 2. Observation audits of dressing changes and overall wounds status by DNS or designee will be completed weekly for 4 weeks and then monthly X 2 months. Audit results will be reviewed by QAPI committee for further recommendation. Completion Date: 8-12-16	

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 _____	07/08/2016

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 309	Continued From page 11	F 309		

Data Collection (WDC) sheets completed related to the pressure ulcers on the toes. The WDC sheet prompted staff to identify if R11 had pain related to the pressure ulcers. Of the 16 WDC sheets, no pain was identified seven times and pain was identified 9 times. Although there was an area to identify interventions implemented for the identified pain, interventions were not consistently identified for the pain. Interventions implemented included loosening the dressing, as needed Tylenol, and repositioning. The efficacy of these interventions was not documented and the care plan did not include the non-pharmacological interventions.

A Good Samaritan Society Wound RN Assessment dated 7/6/16, indicated R11 had a pressure ulcer located on her toe.

During an interview on 7/6/16, at 8:39 a.m., R11 stated her feet hurt. She stated the nurse had changed the dressing to her foot and stated, "now it will hurt almost until dinner time."

During an observation on 7/7/16, at 9:43 a.m., licensed practical nurse (LPN)-A completed a dressing change to R11's wound on her toes. While LPN-A was applying the anti-embolism hose to her left foot R11 visibly flinched.

During an observation on 7/8/16, at 1:33 p.m. the DON was observed completing a wound treatment to R11 left toes. When R11's sock was removed she moaned, "Ohhhhhh," and grimaced. As the DON separated her toes to assess the wound, R11 again began moaning, "Oh, oh" and grimacing. The DON asked R11 how her toe was and R11 stated, "it hurts" and rated her pain "about a 7-8/10." The DON asked if Tylenol would

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 _____	07/08/2016

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 309	Continued From page 12	F 309		

help with the pain and R11 stated Tylenol does help. The surveyor asked the DON to stop the dressing change to R11's toes until she could be medicated due to R11's verbal and non-verbal indicators of pain.

During a subsequent interview on 7/7/16, at 1:04 p.m., R11 stated her toes were hurting. She stated she doesn't tell anyone when her feet hurt and stated no one asks her about pain. R11 stated her feet hurt every day and rated the pain at 8/10 on average. She stated she has trouble sleeping because of the pain and stated when she received Tylenol it helps with the pain.

During an interview on 7/7/16, at 1:09 p.m., LPN-A stated R11 does not complain when she has pain. LPN-A further stated staff only ask about pain if a resident requests something "otherwise we don't ask."

During an interview on 7/7/16, at 1:48 p.m., the DON stated if there was an increase in a resident's level of pain she would expect the physician to be notified and would expect staff to monitor the resident for pain every shift. The DON stated the nurses ask about pain every shift unless the resident is on a scheduled narcotic pain medication. The DON further stated the RN should be evaluating each assessment, looking for changes and implementing interventions when needed. She stated R11 should be monitored for pain regularly.

During an interview on 7/8/16, at 9:52 a.m. LPN-B stated R11 gets a treatment to her foot every day and stated, "she does have pain during the treatment."

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 _____	07/08/2016

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 309	Continued From page 13	F 309		

A review of R11's Medication Administration Records dated June 2016 and July 2016 indicated she received Tylenol six days during the month of June and two days during the month of July even though staff indicated they were aware she had pain with dressing changes which occurred daily.

While R11 had an increase in her pain level that was affecting her ability to sleep and her daily functioning and had pressure ulcers on her toes which caused her pain during treatments, staff was not assessing her pain regularly. Further, while staff had knowledge that R11 would not ask for pain medication, there was no evidence staff offered interventions to help alleviate her pain.

The Good Samaritan Society Pain Management-Resident Assistance policy, dated September 2012 indicated: all employees will be engaged in the recognition, skilled observation/assessment, treatment and management of pain. The policy further indicated when a resident is identified as being in pain, the nurse working with the resident must continually monitor and observe the resident for pain management and report to the prescriber as necessary to keep the resident comfortable.
R17 was interviewed on 7/7/16, at 7:55 a.m. in his room and confirmed the nurse's change a dressing to the bottom of his left foot every other day and wrap both of his legs. R17 stated he had a circulation problem and the lower half of his legs have been reddened for over a year due to circulation problems however, R17 denied any oozing of the legs. The resident stated he'd had the open area on the bottom of his left foot for over a year. He stated he had no feeling in his left foot due to diabetes.

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 _____	07/08/2016

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 309	Continued From page 14	F 309		

During observation at 11:00 a.m. on 7/8/16, R17 was observed seated in his oversized chair. He was dressed except for his feet, which were exposed bilaterally. The resident said he'd had a bath that morning & was waiting for the nurse to come in and perform a dressing change to his left heel area, and to a burn area on his left ankle (which had been identified on 5/23/16). At the time of the observation, R17 stated again that he had no feeling or sensation in his left lower leg due to diabetic neuropathy. During the observation, an open area was also observed on the resident's left ankle.

R17's record indicated he had been readmitted to the facility on 6/27/14. The following diagnoses were identified on the face sheet: diabetes mellitus, neuropathy, and pressure ulcer of left heel (originated 9/23/15).

R17's Care Area Assessment (CAA) done on 5/10/16, triggered for pressure ulcers and indicated additional diagnoses including: immobility, incontinence, altered mental status related to cognitive loss, chronic or end-stage renal failure, depression, severe pulmonary disease and pain. An assessment of cognition had been completed for R17 on 5/11/16, and indicated no cognitive impairment.

A Nursing Progress Note dated 7/8/16 revealed, "dressing changes completed to burned area of left lower leg and left heel. See assessments for specifics of measurements. R17's F-M was notified of new area on left inner ankle. F-M stated that came from peeling off dried skin in that area and that F-M was aware of it. R-17 would be seen by his primary medical doctor

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 _____	07/08/2016

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 309	Continued From page 15 (MD) on next rounds." Wound assessments done on 7/8/16, indicated the left lower leg had an open area from a traumatic wound with a partial thickness loss of tissue. The assessment indicated the wound was not debrided but would receive a wound treatment. The area was identified as measuring 1.3 centimeters (cm) by 2 cm. There were no Physician's Orders for treatment of the new wound. During an interview with the director of nursing (DON) on 7/8/16, at 11:05 a.m. the DON stated she completed weekly wound assessments on Fridays. Furthermore, the DON also confirmed she did not know about the new wound to R17's left ankle. She said the nursing assistant taking care of R17 had not informed her of any new skin problems observed during R17's shower that morning. Following the interview, a review of documentation was conducted and it was noted there was a lack of documentation of weekly wound assessments. After the open area was brought to the DON's attention on 7/8/16, a Wound RN Assessment was documented: the wound was described as measuring 1.3 by 2 cm and was documented as a traumatic wound (typically defined as cuts, lacerations or puncture wounds which have caused damage to both the skin and underlying tissues) on the assessment. Nursing assistant (NA)-C was interviewed on 7/8/16 at 12:20 pm, and confirmed she had assisted R17 with a shower that morning. NA-C verified she was not aware the resident had a new open area. NA-C stated she'd only just told	F 309		

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 _____	07/08/2016

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 309	Continued From page 16 the nurse that the resident was ready to have his dressings changed. NA-C said it had been at least a week since she had taken care of the resident. The resident's care plan indicated the nurse was to be notified immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc. noted during bath or daily cares.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess and implement interventions to prevent worsening of pressure ulcers for 3 of 4 residents (R11, R52, R23) who were reviewed for pressure ulcers. This resulted in actual harm for R11 as the facility failed to accurately assess and implement pressure ulcer care prior to prevent R11 from developing multiple and/or recurring pressure ulcers to her toes. In addition, the facility failed to turn and reposition R23, and provide a pressure reducing cushion in the Broda chair resulting in	F 314	F-314 R11 had appointment with vascular physician 7-28-16 who diagnosed her with arterial ulcers on left third, fourth and fifth digits. New treatment has been received, care plan has been updated. R-52 bed overlay is no longer being used and heel is healed. R-23 has had cushion placed in Broda chair, positioning assessment and evaluation completed, care plan updated to reflect findings of current needs.	8/12/16

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 _____	07/08/2016

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 314	Continued From page 17 the development of a stage 2 pressure ulcer (partial thickness loss of skin due to pressure). Furthermore, the facility failed to timely intervene for a malfunctioning bed overlay which caused an unstageable ulcer (Full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed) on R52's heel. Findings include: R11 had a pressure ulcer on her left third toe caused by hammer toes measuring 1 centimeter (cm) x 1 cm according to the Wound Data Collection assessment dated 4/5/16. The wound was described as having a white center with intact surrounding tissue. Documentation by the wound RN (registered nurse) on the Wound Data Collection assessment dated 4/5/16, described the wound as non-pressure related. However, the wound RN's assessment dated 4/10/16, described the wound as pressure related. A wound assessment dated 4/17/16, indicated the wound had decreased in size and measured 0.25 cm x 0.25 cm. A wound data collection assessment dated 4/23/16, indicated the wound on R11's left third toe had increased in size again to 1 cm x 0.5 cm and described the wound as containing 80% slough (when a layer of necrotic tissue separates from the living healthy tissue). The pressure ulcer was coded as a stage II on the 4/23/16, assessment. A 4/28/16, assessment indicated the wound was still present on R11's left third toe and measured 1 cm x 0.5 cm. A 5/4/16, assessment indicated no change in the size of the wound and described the wound as superficial with a reddened top layer. An assessment conducted 5/8/16, indicated the	F 314	All current residents with a Braden scale showing them at risk will have a positioning data tool completed to include pressure relieving devices and the findings from the tool will be updated to the care plan by 08/12/2016. Nursing staff were educated on wound measurements and staging of wounds on 7-18-16 by AMT Consulting Wound Nurse. Nursing staff will also be re-educated on the Wound Data Collection tool and RN Wound Assessment and their usage 08/02/2016. Nursing staff will also be educated on notification of new skin issues to physicians for change in treatment/follow up 08/02/2016. Record review on wound data collection tools and RN Wound Assessment will be completed weekly x 4 and monthly x 2. Observation audits on overall wound status and pressure relieving devices by DNS or designee will complete weekly audits for 4 weeks and then monthly X 2 months. Audit results will be reviewed by QAPI committee for further recommendation. Completion Date: 8-12-16	

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 _____	07/08/2016

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 314	Continued From page 18	F 314		

wound was superficial with less redness noted. On 5/11/16, the wound had been measured to be 0.5 cm x 0.5 cm. The wound was not measured again until 5/23/16, when the nurse practitioner assessed the wound.

A Progress Note dated 5/23/16, signed by the nurse practitioner, indicated R11 now had two separate wounds and described them as follows: Lateral area of third toe- 1.3 cm x 1 cm, 100% whitish-yellow slough, Medial of fourth toe 0.5 cm x 0.5 cm, 100% yellow slough with red edges.

On 5/26/16, the RN assessment indicated pressure ulcers on both the 3rd and 4th toes of R11's left foot. There was one measurement included indicating 1 cm x 1 cm and indicating a depth of 0.25 cm. The assessment did not identify which toe was measured.

A Good Samaritan Society Wound data Collection assessment dated 5/29/16, indicated measurements of 0.25 cm x 0.25 cm x 0.1 cm on R11's left toe and described the wound as 90% slough but did not identify which toe was measured.

The next assessment dated 6/7/16, indicated a wound on the left toes measuring 1 cm x 1 cm x .02 cm but did not identify which toe was assessed.

On 6/14/16, the wound measured 1 cm x 1 cm x .01 cm and noted "other area" 0.5 cm x 0.5 cm. The assessment indicated the wound bed contained 10% slough but did not identify which wound was assessed. The RN assessment continued to identify the pressure ulcers as stage II, even though slough was described as present

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 _____	07/08/2016

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 314	Continued From page 19 in the wound bed. R11's quarterly Minimum Data Set (MDS) dated 6/14/16, indicated she was cognitively intact and required extensive assistance with all activities of daily living. The MDS further identified a stage II pressure ulcer present since 4/5/16. The next assessment dated 6/20/16, indicated a wound on the left foot that measured 0.25 cm x 0.25 cm x .02 cm but again did not identify which toe was being assessed. A Progress Note dated 6/20/16, signed by the nurse practitioner, identified the following assessment of R11's left foot: Lateral of third toe 1.3 cm x 1 cm, 100% white slough and medial of fourth toe 0.5 x 0.5 cm with 100% yellow slough. R11's care plan dated 6/29/16, indicated a stage II pressure ulcer had been present since 3/22/16. No further measurements were completed until 7/6/16. A Good Samaritan Society Wound RN Assessment dated 7/6/16, identified a stage II pressure ulcer on R11's left toe. The assessment did not include measurements, nor did it identify number or location of pressure ulcers. Although the facility had observations of R11's pressure ulcers at least weekly, there was no evidence both wounds were being assessed following the identification of the second pressure ulcer on 5/23/16. Further, while both pressure ulcers on R11's left toes contained slough, the facility continued to stage the ulcers at a stage II even though the presence of slough in the wound bed indicates an unstageable pressure ulcer (full-tissue thickness loss in which the base of the	F 314		

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 _____	07/08/2016

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 314	Continued From page 20	F 314		

ulcer is covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed).

During an observation on 7/8/16, the director of nursing (DON) performed an assessment of R11's pressure ulcers. Upon assessment, the DON stated "there are actually three" pressure ulcers (only two were previously identified). The DON stated there was slough present in the wound bed between the 4th and 5th toes and described the wound as a stage II pressure ulcer. She stated between the 3rd and 4th toes were two stage III pressure ulcers (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue), one on each side. She stated both were approximate 2 cm x 2 cm. The wounds were not observed as the resident was in alot of pain when the toes were being spread and the procedure was stopped.

During an interview on 7/8/16, at 9:52 a.m., licensed practical nurse (LPN)-B stated R11 had a treatment done every day to her toes however LPN-B stated she had not seen them lately.

During an interview on 7/8/16, at 9:54 a.m., LPN-C stated she saw R11's wounds on the previous Sunday. She stated, "she (R11) had sores on two of her toes and both areas were open."

During an interview on 7/8/16, at 1:04 p.m., the DON stated an RN was responsible for wound data collection. She stated it should be done with every dressing change and stated the

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 _____	07/08/2016

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 314	Continued From page 21	F 314		

measurements should be done weekly with the RN assessments. The DON stated she had been present when the nurse practitioner had assessed R11's wounds but stated she had not seen the wounds. The DON further stated she was not aware of whether the wounds had increased or decreased in size since they were first assessed.

A facility policy titled Good Samaritan Society Pressure Ulcers, September 2012, indicated the facility will use prevention and assessment interventions to ensure a resident entering the center without pressure ulcers does not develop them. The policy further indicated a resident who develops a pressure ulcer will receive the necessary treatment and services to promote and maintain skin integrity.
R52 was continuously observed on 7/7/16, from 7:30 a.m. until 9:45 a.m. At 7:30 a.m. R52 sleeping in bed. At 7:46 a.m. R52 was lying flat on his back in bed, with the head of bed elevated 45 degrees heels. R52 had a wedge under both legs, feet, heels and his lower legs were covered with yellow sheepskin like material. The heels were floated. There was a pillow under each elbow. At 7:50 a.m. nursing assistant (NA)-A entered the room and spoke with R52, NA-A requested a tray be brought to the room and moved the over bed table and chair to the side of R52's bed. NA-A did not reposition R52 but fed R52 breakfast. At 8:17 a.m. NA-A reclined R52's bed slightly to 40 degrees, put the chair away and left room. At 9:32 a.m. NA-B entered the room and asked R52 if staff could clean him up. R52 was lying on bed on his back with the head of his bed elevated and a wedge pillow under his legs and body pillow along the resident's right side. NA-A and NA-B proceeded to provide morning

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 _____	07/08/2016

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 314	Continued From page 22	F 314		

cares to R52. NA-A boosted R52 up in bed following provision of cares. They again placed the wedge pillow so R52's heels were floated. R52 was lying flat on back in same position as prior to incontinence care was done with head of bed up 30 degrees. NA-B placed a pillow along R52 s left side and NA-A placed a pillow along R52's right side.

The Positioning Assessment & Evaluation dated 6/13/16, assessment and evaluation section indicated, "new resident, hospice end stage cancer, needs extensive assist of two to reposition, skin intact. Incontinent of bowel and bladder, wears brief, Broda chair for positioning, but has not been getting out of bed." The Care plan section indicated support surface was an air mattress.

R52's Admission MDS dated 6/17/16, indicated R52 was moderately cognitive impaired and required assistance with bed mobility, transfers, eating and toileting. R52's face sheet indicated R52's diagnoses included prostate cancer, diabetes, and atrial fibrillation.

The Care Plan dated 6/17/16, indicated R52 had an unstageable right heel pressure ulcer related to end stage (prostate) cancer with metastasis, on hospice. Staff were instructed to assist to reposition at least every hour, to assess, and to record and monitor wound healing daily. Care plan also instructed staff to provide air mattress device on bed, provide pressure skin protective devices for elbows and heels.

Pressure Ulcer Care Area Assessment (CAA) dated 6/20/16, indicated R52 was at risk for developing pressure ulcers, had an unstageable

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 _____	07/08/2016

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 314	Continued From page 23	F 314		

pressure ulcer. The CAA also indicated R52 was frequently incontinent of bowel and bladder. The interventions identified on the CAA included air mattress, reposition every two hours, boot for foot, daily monitoring and hospice care with goal of care to minimize risks and symptom relief.

The Visual/Bedside Kardex Report printed 7/8/16, instructed staff turn from side to side, provide air mattress device heels boot remove twice daily for cares, lotion area.

During interview on 7/7/16, at 9:50 a.m. NA-B stated we turned him off his back when we cleaned his bottom and then turned him back to his back.

During interview on 7/7/16, at 9:55 a.m. NA-A said R52 mostly likes to sit upright. When he wants to be on his side, he will let us know.

During interview on 7/7/16, at 10:15 a.m. Resident stated, unable to turn side to side because he has to keep his feet pointed toward the ceiling because of the sore on his heel.

During interview on 7/8/16, at 12:29 p.m. the DON said, "He came in without any pressure areas." DON said there had been an air overlay on the bed, but it was not working due to the wrong pump being attached from the time of admission until we noticed the pressure ulcer seven days after admission. We replaced the air overlay with a new mattress. DON said, "He is to be repositioned frequently, at least every two hours. As long as he was off loaded for at least three minutes they can put him back on his back."

R23 was observed sitting up in Broda chair

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 _____	07/08/2016

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 314	Continued From page 24	F 314		

watching television (TV) in the day room. No cushion in chair at 3:56 p.m. on 7/6/16. At 4:03 p.m. that same day, R23 said the Broda chair was new and added, "It is not comfortable."

During frequent observations on 7/7/16, from 7:52 a.m. to 10:05 a.m. the following was observed:
-7:52 a.m. R23 sitting in Broda chair in his room. NA-B was shaving R23.
-8:21 a.m. R23 sitting in day room in Broda chair watching TV.
-9:03 a.m. R23 remains sitting in same position.
-9:48 a.m. R23 same position watching TV.
-10:05 a.m. R23 in same position watching TV.

R23's significant change MDS dated 5/9/16, indicated R23 was severely cognitive impaired and required assistance with bed mobility, transfers, eating and toileting. R23's MDS indicated R23's diagnoses included dementia, and arthritis. MDS indicated R23 was at risk for pressure ulcer development, with pressure reducing device for chair and bed and turning and repositioning program.

A Pressure Ulcer Care Area Assessment dated 5/11/16, indicated R23 required a specialty mattress or seat cushion to relieve pressure, and regular schedule of turning and repositioning.

A Wound Data Collection dated 7/3/16, indicated R23 had a stage two pressure ulcer on his right buttock, measuring 0.25 cm. x 0.25 cm. The section for modification to interventions was blank.

The resident's care plan printed 7/18/16, indicated R23 had potential impairment to skin

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 _____	07/08/2016

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 314	Continued From page 25 (revised 12/9/14), and interventions indicated staff needed to ensure a pressure reducing mattress to protect skin in bed, Broda chair and to elevate heels while in bed. The care plan did not address turning, repositioning or history of frequent pressure ulcer development. During interview on 7/8/16, at 9:58 a.m. the DON said was she was unaware R23 had a pressure ulcer. The DON stated pressure ulcers should be care planned immediately. DON said, "About a week ago his cushion started leaking so we are getting a new cushion, but it is not here." The DON said R23 had a history of pressure ulcers opening and closing. The DON said, "I would expect them to reposition him every two hours when in the chair."	F 314		
F 328 SS=G	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 interview and document review, the facility failed to provide adequate monitoring of respiratory symptoms for 1 of 1 resident (R55)	F 328	F-328 R-55 is no longer resident at facility. Facility has since contracted with a new	8/12/16

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 _____	07/08/2016

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 328	Continued From page 26 reviewed for respiratory status. This resulted in actual harm to R55 who required hospitalization for an acute respiratory issue. Findings include: Review of R55's Admission Record indicated R55 had been admitted to the facility on 10/23/15. According to the Admission Record, R55's admission diagnoses included: acute respiratory failure and congestive heart failure (CHF). The Hospital Discharge Orders included oxygen via nasal cannula to keep oxygen saturation levels (a term referring to the fraction of oxygen-saturated hemoglobin relative to total hemoglobin (unsaturated + saturated) in the blood. The human body requires and regulates a very precise and specific balance of oxygen in the blood. Normal blood oxygen levels in humans are considered 95-100 percent) equal to 90% and BIPAP at night (BIPAP refers to the use of a breathing apparatus that helps the user get more air into his/her lungs and is useful in aiding with sleep apnea) and daily weights due to CHF. R55's care plan dated 10/24/15, identified a problem area of congestive heart failure exhibited by the need for oxygen therapy, and limited physical mobility related to respiratory failure. Care plan interventions directed staff to weigh R55 every morning, monitor for labored breathing, apply oxygen, and to ensure R55 used the BIPAP machine at night and during naps. The resident's Nursing Progress Notes indicated the following: On 10/23/15, R55 admitted to the facility. His CPAP [BIPAP] machine was unusable upon admission. Allina home oxygen was contacted	F 328	Oxygen provider who has better response time for equipment needs. New admissions will have vitals to include oxygen saturation and respiratory assessment every shift for 72 hours. Residents with acute respiratory symptoms will have vitals to include oxygen saturation and respiratory assessment completed until symptoms resolve. Licensed staff to be re-educated on policy and procedure related to respiratory monitoring and ensuring proper equipment is available and operational on 08/02/2016. Observation audits of respiratory assessments will be done weekly x4, then monthly x 2 by DNS or designee. Record review audits of new admissions and residents with acute respiratory symptoms weekly x 4 weeks, then monthly x 2. Audit results will be reviewed by QAPI committee for further recommendation. Completion Date: 8-12-16	

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 _____	07/08/2016

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 328	Continued From page 27	F 328		

and will bring out new supplies on Monday (10/26/15). A subsequent progress noted dated 10/23/15, indicated R55 displayed shortness of breath, received a nebulizer treatment, and was receiving oxygen via nasal cannula. However, the progress note did not indicate R55's oxygen saturation levels. A Nursing Progress Note dated 10/25/15, indicated a call had been placed to the hospital to request the on call physician contact the facility regarding R55. The notes indicated a physician had called back and requested R55 be seen in the emergency room. Another progress note dated 10/25/15, indicated R55's oxygen saturation level had measured 80% prior to R55 having been sent to the hospital by ambulance. R55 did not return to the facility.

A Good Samaritan Society Discharge Summary dated 11/2/15, indicated R55 had been discharged from the facility on 10/25/15, at 6:28 p.m., and R55's family did not want him to be readmitted to the facility. The Hospital Discharge Summary dated 11/1/15, indicated R55 had presented to the hospital from Good Samaritan Society Winthrop with shortness of breath and hypoxia. (Hypoxia indicates there is not enough oxygen reaching the body's tissue). The Hospital Discharge Summary further indicated R55 had been treated for fluid overload as well as "untreated sleep apnea (had not been using his BIPAP)."

R55's Medication Administration Record (MAR) dated October 2015, indicated R55's BIPAP machine had been prescribed but not used while at the facility. In addition, an order for DuoNeb solution every four hours as needed for shortness of breath was in place however, R55 had not received the DuoNeb (breathing medication) on

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 _____	07/08/2016

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 328	Continued From page 28	F 328		

10/25/16, when the progress notes described him as short of breath. The MAR did not include the order for oxygen, nor was there evidence of monitoring oxygen saturation levels even though hospital After Discharge Orders dated 10/23/16, included Oxygen per nasal cannula to keep oxygen saturation greater than or equal to 90%.

A review of Good Samaritan Society - Winthrop Weights and Vitals Summary was reviewed for R55 from 10/23/16 through 10/25/16. All of the vitals signs were reviewed and only two oxygen saturations were recorded. The one level of the two levels recorded was recorded on 10/24/16, and indicated 90% on oxygen.

During an interview on 7/7/16, at 1:46 p.m., licensed practical nurse (LPN)-A stated she was working the day R55 was sent to the hospital but could not remember why he had been sent in.

During an interview on 7/7/16, at 1:46 p.m., the director of nursing (DON) stated R55 had been admitted to the facility on a Friday and had been discharged while she was on vacation. Consequently, the DON did not know R55 and was unfamiliar with why he had gone to the hospital.

During an interview on 7/8/16, at 11:23 a.m., family member (F)-A stated she had visited R55 on both Friday and Saturday after his admission. She stated when she'd visited on Sunday R55 had a grayish color and was having difficulty breathing. F-A stated she had gone to find a nurse but that it had taken awhile. F-A stated when she had found the registered nurse (RN), the RN had given her an oximeter and asked her to check R55's oxygen levels. F-A stated when

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 _____	07/08/2016

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 328	Continued From page 29	F 328		

she'd checked R55 his oxygen saturation level was at 68%.

During an interview on 7/8/16, at 11:35 a.m., the administrator stated R55 had been a resident prior to when she (the administrator) had started at the facility, but that she had done some research regarding the issue. The administrator verified R55 had been admitted to the hospital with acute respiratory failure and hypoxia and had not returned to the facility after hospitalization.

During a subsequent interview on 7/8/16, at 12:19 p.m., the DON confirmed R55 had been admitted with respiratory failure and should have been monitored for respiratory status including oxygen saturation levels, lung sounds and respirations each shift. The DON further stated when the facility learned that R55's BIPAP machine was not useable, the facility should have made arrangements to have a new machine delivered immediately to the facility. In addition, the DON said since R55 did not have the BIPAP as ordered during his stay at the facility, she would have expected additional monitoring. No further interventions were put into place for R55 as R55 did not return to the facility and the facility had no other admissions with BIPAP (CPAP) machine.

The registered nurse-A was unavailable for interview.

The facility policy for Respiratory Care dated September 2012, indicated respiratory care services would be provided by the center or an outside source and available at all times. The policy further indicated respiratory care would be provided according to the physician's order and that residents on respiratory therapy were to be

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 _____	07/08/2016

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 328	Continued From page 30 monitored carefully and observed for signs of inadequate oxygenation or any respiratory complications.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure that 1 of 5 residents (27) reviewed for unnecessary medications, had clear indications, defined parameters, and adequate	F 329	F-329 R-27 medications were reviewed, physician/provider was consulted and parameters have been established.	8/12/16

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 _____	07/08/2016

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 329	Continued From page 31 monitoring for the use of the a hypertensive medications. Findings include: During review of medication orders dated 6/6/16, it was noted R27 had an order for Norvasc 2.5 milligrams every day for hypertension, hold if pulse was less than 50 dated, 3/16/16, but there was no record of pulse checks on the medication administration record. R27's quarterly Minimum Data Set (MDS) dated 5/3/16, indicated R27 was moderately cognitively impaired and had diagnoses of hypertension and Glaucoma. Winthrop Good Samaritan Drug Regimen Review Report dated 2/13/16, indicated R27's pulse rates in previous month ranged from 46 to 64 and blood pressure ranged from 111/57 to 158/84. Norvasc may contribute to bradycardia (a slow heart rate under 60 beats a minute in adults). Request made for R27's physician to define at which pulse rates Norvasc should be held. Physician order dated 3/14/16, "Hold Norvasc if pulse is less than 50." Winthrop Good Samaritan Drug Regimen Review Report dated 5/22/16, indicated R27's pulse rates in previous month ranged from 44 to 56. Pharmacist noted that Norvasc and Zoloft (a medication for depression) have bradycardia listed as adverse effects although it is very rare. The pharmacist also noted R27 was on Combigan (a medication for glaucoma) eye drops which contain a beta blocker the frequency of bradycardia in eye drops unknown. The pharmacist requested physician determine the	F 329	Physician/provider has ordered blood pressure and pulse to be taken before administration of the medication and held if outside of parameters. All resident medication administration records have been reviewed and physician/provider will be contacted to determine medication need and needed parameters by 08-05-16. Education has been provided to all licensed staff and TMAs by consultant pharmacist regarding medications that contribute to hypotension and bradycardia on 7-22-16. Further education was provided to licensed staff and Health Information Manager regarding input of PCC orders with parameter documentation on 08/02/2016. Record review audits will be completed by DNS or designee to assure established parameters are being followed and documented as physician/provider ordered weekly x4 and monthly x2. Audit results will be reviewed by QAPI committee for further recommendation. Completion date: 8-12-16	

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 _____	07/08/2016

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 329	Continued From page 32	F 329		

causes of low pulse rates. The physician response was Norvasc and Sertraline were likely not the cause of R27's low pulse rate.

A review of vital signs in the electronic health record did not show daily pulse checks. The Vital Signs Record indicated R27's pulse on 4/30/16 was 48, pulse on 5/18/16 was 44, pulse on 5/28/16 was 49, and the pulse on 7/2/16 was 44.

A review of the Medication Administration Record from March 1, 2016 through July 7, 2016, revealed there were no missed or held doses of Norvasc.

During interview on 7/7/16, at 1:44 p.m. the trained medication aide (TMA)-A said R27's Norvasc orders do not tell us to take his pulse. TMA-A stated some resident's orders do tell us to check the pulse. TMA-A further commented "the doctor will order it if he wants it done." At 1:46 p.m. surveyor viewed electronic medical record with TMA-A. TMA-A stated "The order to hold the Norvasc is there, but there is not a heart to indicate to check pulse and a pop up does not occur." TMA-A verified there was no place to document the pulse.

During interview on 7/7/16, at 2:27 p.m. the director of nursing (DON) indicated R27's pulse would be located under the weights and vital sign tab in the computer. DON acknowledged there were not daily pulses for R27 prior to medication administration. DON acknowledged R27 had pulses recorded that were below 50. The DON said there could be a lot of risks if R27 was not monitored for the Norvasc and when the pulse was low. R27 could become hypotensive, have unresponsive spells, or could fall. DON stated if a

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 _____	07/08/2016

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 329	Continued From page 33 residents pulse was found in the 40's on a routine vital sign check, "I would expect nurses to give the resident's fluids to drink, monitor and notify the physician."	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not have a system to ensure Fentanyl (a narcotic) patches were accurately destroyed to prevent potential diversion for 1 of 1 resident (R15). Findings include:	F 425	F-425 Medications are destroyed in RX Destroyer pharmaceutical disposal (chemical medications destroying liquid) to include used narcotic patches. This procedure is witnessed by 2 licensed staff or licensed staff and administrator and	8/12/16

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 _____	07/08/2016

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 425	Continued From page 34 On 7/5/16, at 5:32 p.m. a tour of the medication cart was completed with licensed practical nurse (LPN)-B who provided access to the medication cart and the narcotic box. Inside the narcotic box to the back was observed an opened box of Fentanyl patches for R15. When asked what the facility procedure was for destroying used patches LPN-B stated one nurse removes the patch from the resident and puts a new one on. The nurse puts the use patch in the medication room on the counter. When a second nurse gets here the two nurses destroy the fentanyl patch after verifying that the date on the patch was the date that was recorded it was put on. "I do not think we have a policy for destruction." R15's Medication Review Report dated 6/6/16, indicated R15 had an order for the Fentanyl patch 72 hours 75 microgram /hour. R15's diagnoses included chronic pain syndrome and dementia quarterly Minimum Data Set dated 6/14/16. During review of R15's Medication Administration Record dated 6/1/16, through 7/6/16, it was revealed R15 had the Fentanyl patch removed and disposed of 11 times with only one nurse signing off. It could not be determined if there were two nurses as only one nurse signed off for applying of the Fentanyl patch. Staff unable to provide destruction/removal documentation. During interview on 7/5/16, at 5:34 p.m. the director of nursing (DON) stated the facility did not have a specific policy for fentanyl patch destruction. Requested controlled substance destruction policy.	F 425	signed off on appropriate forms. Current and future resident medications including used narcotic patches will be destroyed in RX Destroyer pharmaceutical disposal. This procedure is witnessed by 2 licensed staff or licensed staff and administrator and signed off on appropriate forms. Education will be provided to licensed staff about facility specific medication and used narcotic patch destruction procedure on 08-05-16. DNS or designee will complete an observation audit of all discontinued medication destruction every day as needed X 2 weeks, then weekly x 4, then monthly x 2. Audit results will be reviewed by QAPI committee for further recommendation. Completion Date: 8-12-16	

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 _____	07/08/2016

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 425	Continued From page 35 During interview on 7/5/16, at 7:32 p.m. LPN-F said, "We put the used Fentanyl patch on the counter in the medication room until there are two nurses to destroy the medications." When asked if they document the destruction LPN -F said, "No." During interview on 7/7/16, at 2:36 p.m. DON said have nurse sign off they put the fentanyl patch in the medication room until we have two nurses and then they put it into Rx (prescription) Destroyer. "There is a locked cupboard in the medication room that they put the patch in, so it is double locked until the nurses destroy them." During interview on 7/7/16, at 2:49 p.m. LPN-A said, "We remove the fentanyl patches and put it on the counter in the med [medication] room until there are two nurses to put it in the Rx Destroyer." Controlled Substance Policy dated 5/28/16, provided on 7/5/16, by DON instructed staff : Every time the keys that secure medications change from one nurse to another, the oncoming and off going nurses work together to count all controlled substances, including discontinued controlled substances. If new controlled drugs are delivered, the licensed nursing staff member on duty at the time of delivery is responsible for counting and locking up these substances and adding to the count in the Individual Resident's Narcotic Record (GSS [Good Samaritan Society] #247). The assess system used to lock Schedule II medications and other medications subject to abuse cannot be the same access system used to obtain the non-scheduled medications. Schedule II medications needing refrigeration will	F 425		

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 _____	07/08/2016

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 425	Continued From page 36 be stored in a separately locked permanently affixed compartment. Medications aides may participate in the controlled substance count only if the state allows. Two nurses or a nurse and pharmacist or nurse and practitioner will always sign for the destruction of controlled medications as allowed by state law. Medications will be placed in the RX Destroyer for disposal. State-specific regulations regarding medication destruction must be followed. Transderm Patch Application policy revised 5/16, provided by DON 7/8/16, before exit instructed staff: when removing a previously placed patch, use caution to protect skin. Fold the patch in two with the medicated sides together. Place old patch in two licensed stick bag for transport to medication room for disposal by licensed professionals. It is not acceptable to put used patches in a sharps container." In addition it instructed staff: "If the patch contains a controlled substance, it must be destroyed with two nursing staff members and destroyed as any controlled substance. Do not dispose of old patches in sharps containers. If it is not possible to immediately put the used patch into a DEA [Drug Enforcement Administration] authorized collection receptacle, the FDA [Federal Drug Administration] recommends flushing Duragesic patches because they are especially harmful in small doses. This should be documented on the Individual Resident's Narcotic Record (GSS #247). It is Society policy that two nurses, or a nurse and pharmacist or a nurse and provider, always sign for destruction of narcotic patches. State-specific regulations regarding medication destruction must be followed."	F 425		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		8/12/16

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 _____	07/08/2016

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 441 SS=D	Continued From page 37 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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 _____	07/08/2016

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 441	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a wound dressing change according to the facility's policy for 1 of 1 resident (R17) to prevent cross contamination of an open wound. In addition, the facility failed to ensure appropriate hand hygiene and glove usage for 1 of 1 resident (R52) who was observed for incontinence care. Findings include: R17 was interviewed on 7/7/16, at 7:55 a.m. in his room and confirmed the nurse's change his dressing on his bottom left foot every other day and wrap both of his legs. In addition, R17 confirmed he had a circulation problem and the lower half of his legs have been reddened for over a year due to circulation problems. R17 denied any oozing of legs. The resident stated he had the open area on the bottom of his left foot for over a year and stated no feeling in his left foot due to diabetes. R17 had a shower completed on the morning of 7/8/16. The resident was observed at 11:00 a.m. in his oversized chair, dressed except his feet were exposed, bilaterally, waiting for the nurse to come in and perform dressing changes to his left heel area and to a burn area of his left ankle (identified on 5/23/16). There was a new open area on the lower left foot which the resident indicated he did not know about when he was questioned about his open wounds on 7/8/16, at 11:05 a.m. In addition, R17 stated he had no feelings or sensations in his left lower leg due to diabetic neuropathy.	F 441	F-441 R17□s wound dressing changes are being completed per physician/provider orders and facility dressing change policy. R52 is receiving appropriate hand hygiene and glove usage by staff when receiving incontinence care. All current and future residents will receive appropriate dressing changes, hand hygiene and glove usage by staff when receiving incontinence care. Licensed staff will be re-educated on dressing change policy/procedures on 08/02/2016. All nursing staff will be re-educated on hand washing techniques by 08/12/2016. Non-licensed staff will be re-educated on peri-care by 08/12/2016. DNS or designee will complete observation audits for dressing changes, peri-care, and hand washing procedures weekly X 4 and then monthly X2 for compliance. Audit results will be reviewed by QAPI committee for further recommendation. Completion date: 8/12/16	

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 _____	07/08/2016

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 441	Continued From page 39	F 441		

Dressing changes done by the director of nursing (DON) were observed on R17 on 7/8/16, at 11:10 a.m. in the resident's room while the resident sat in an oversized stuffed chair. The DON obtained a dressing tray from R17's bedside stand. The dressing tray had multiple sterile dressings, some open dressing packages, a mirror that was approximately 6 x 6 inches with a long handle, and a scissor. The DON washed her hands in the sink in the bathroom and after drying her hands put on gloves. While donning the gloves, the DON indicated the registered nurses (RN's) at the facility do the assessments and the licensed practical nurses (LPNs) collect data for the RN's to include any changes in the skin related to new redness and swelling. In addition, while donning the gloves, the DON touched her face and hair with the already gloved hand. The dressings on the left foot had been removed before R17 received his shower that morning. The DON observed the three open areas before measuring them. The burn area near the left ankle was "scabbed over" and no longer open. The heel area according to the DON was "much smaller." The DON confirmed that there was a "new open area" just above and to the side of the ankle. The DON then removed the gloves and discarded them in a wastebasket. She washed her hands in the bathroom sink, gloved, and then got out the wound cleaner from the bathroom area. The DON had a difficult time observing the heel and pulled the mirror from the dressing tray to look at the wound. LPN-B came into the room to check on the resident and the DON asked LPN-B to assist her with measuring the heel wound by holding up the left foot. The DON used the mirror to observe the heel wound further and obtained a measured circular wheel measuring device. The DON

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 _____	07/08/2016

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 441	Continued From page 40	F 441		

measured the heel wound while LPN-B held up the foot. The measurements of the heel wound were 1.4 by 0.8 and the scabbed area was 3.0 by 3.3 cm. After measuring the wound the DON placed the mirror face down on the floor in front of the chair. There was a full urinal to the left of the mirror on the floor. The measuring device was placed on the bedside table face down, the area that had touched the wound contaminating the bedside table. The DON removed her gloves, dropped them in the wastebasket and once again washed her hands in the sink and donned a new pair of gloves. The burn area was measured using a second measured circular wheel measuring device. The wound measured 3.0 by 2 cm and once again the DON stated that was a stage 2 (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) had partial thickness loss. The measuring device was then placed on the resident's computer top face down which had touched the resident's wound area contaminating the lap top cover. The DON then discarded the gloves in the waste basket and went to the bathroom to wash her hands and donned another pair of gloves. The DON then took out dressing from the dressing tray and placed them on the top of the back of the mirror. The edges of the enclosed dressing packages touched the floor. The newly acquired area on the left ankle was measured with a measuring device. The open area measured 3.0 by 3.0 by 5 cm and was a stage 2. The measuring window was put on the over-bed table on the flat surface which touch the top of the table contaminating the area. The heel wound was cleansed with a wound cleanser, patted dry with a 4 x 4 gauge and would touch her face and hair as she cleansed the wound. The

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 _____	07/08/2016

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 441	Continued From page 41	F 441		

DON then took the Iodosorb tube and squeezed the gel onto her pointer finger left hand. As the DON was about to apply the Iodosorb to the heel wound she was stopped by the observer. When questioned about her technique, she admitted that she had contaminated her glove by touching her hair and face with her gloves and should have used an applicator to put the Iodosorb on the wound. The DON then removed her glove, put on another pair of gloves and that time applied the Iodosorb gel with an applicator. A foam dressing was applied and a gauze wrap was applied leaving open the burn wound and the new found open area. The DON then discarded the gloves, and washed her hands, and donned another pair of gloves. The DON then cleansed the burn area with a wound cleaners and applied two layers of perform. The newly acquired area was cleaned with wound cleanser and then a Kerlix was applied to area since there were dressing no orders for this wound. The DON stated she would call the physician to let him know about the new open area. Kerlix was then wrapped to hold all the dressing in place. The DON then put the resident's tubes on his feet. The DON removed her gloves, placed them in a waste basket, put away the dressing tray, and washed her hands. After leaving R17's room, the DON was asked about the dressing change and confirmed she had not set up a dressing field with a barrier and had placed the dressing on top of the mirror and the dressing did indeed touch the floor. Also confirmed was that the DON was going to apply the Iodosorb after she had contaminated the gel by placing on a glove that she had touched her hair and skin. In addition, the close proximity of the full urinal to the dressings on the mirror and the measuring devices, three, that had been placed on objects face down and these objects

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 _____	07/08/2016

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 441	Continued From page 42	F 441		

were now contaminated were discussed and the DON agreed with the findings. The facility's wound dressing policy was requested.

R17 readmitted to the facility in 2014, with diagnoses on the face sheet listed as diabetes mellitus, neuropathy, and pressure ulcer of left heel as of 9/23/15.

Skin care orders were as follows:
Left buttock:
R17 had a Physician Order dated 12/22/15, for the left buttocks directed nursing staff to care the buttocks one time a day for skin tear apply skin barrier prep around wound (skin protectant), fan dry, apply Duoderm (gel-filled dressing), hold in place for 30 seconds, change only when dressing was peeling up on its own. Check daily for placement.

Left heel:
The most recent Physician's Order for the left heel was dated 2/26/16, and directed nursing staff to use a wound cleanser, pat dry, apply Iodosorb (a dressing that promotes a clean wound healing environment) to wound bed, foam and wrap with Kerlix (a gauze dressing), staff may change every other day. R17 was to have off-loading boot in bed, utilize a heel protector/contracture boot on left heel continuously.

Burn:
A Physician's Order dated 6/14/16, for a burn area on the left ankle directed nursing staff to apply wound cleanser, apply two layers xerform, Kerlix loosely, change daily. One time a day for wound care.

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 _____	07/08/2016

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 441	Continued From page 43	F 441		

New open left outer ankle:
A new open area on the left ankle was discovered after R17 had his shower on 7/8/16, on the left ankle. The Physician Orders for the new wound treatment was requested on 7/8/16, and no Physician Orders were received on the treatment of newly identified wound.

The DON was interviewed on 7/8/16, before the dressing change at 11:10 a.m. and confirmed she did not know about the new wound on the left ankle and that the nursing assistant taking care of R17 had not informed her of any new skin problems observed during R17's morning shower.

The facility's policy, Wound Dressing Change, revised 5/16 indicated the purpose of the policy was to promote wound healing and the wound would remain free of infection. The procedure for a wound dressing change was as followed:

"If this is an initial dressing application, complete steps 1 through 4 then skip to step 8 and complete process.
1. Check physician's order; review previous assessment and notes.
2. Perform beginning five.*
3. Position resident for comfort and to accommodate dressing change.
4. Put on gloves.
5. Loosen tape from resident's dressing or press down on surrounding skin gently and carefully lift one edge of the dressing from the skin. Continue to carefully lift the edge by moving slowly around the ulcer margins until all edges are free.

For residents with particularly fragile skin, use a product designed to loosen adhesive to protect

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 _____	07/08/2016

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 441	Continued From page 44	F 441		

skin from tearing and provide resident more comfort with dressing change.

6. Remove slowly, folding dressing over itself and pulling it in the direction of the hair growth. If the dressing is difficult to remove, loosen edges with a warm, wet cloth.
7. Remove soiled dressing and discard in plastic bag, avoiding contact and thus contamination of other surfaces. Remove gloves and discard in same plastic bag. Perform hand hygiene.
8. Create field with equipment/dressing wrappers. Use sterile technique if required.
9. Open all supplies and pour solutions if ordered.
10. Put on gloves.
11. Assess wound and surrounding area to ensure the selection of the appropriate -sized dressing.
12. Cleanse the skin and wound thoroughly with normal saline using gauze wipes, wound cleanser or ordered antiseptic solution. Clip excessive hair at site as needed.
13. Allow the skin to dry completely before applying the dressing. If the resident's skin is fragile, or drainage is expected to go beyond the wound edge, consider applying a skin protection preparation around the wound.
14. Remove dressing from the inner wrapper; avoid finger contact with the dressings, seal and discard according to procedure.
15. Place all disposable items in plastic bag with dressings, seal and discard according to procedure.
16. Perform ending five.*
17. Identify time, date and initials on dressing.
18. Chart dressing change and wound observation on the Wound Data Collection.

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 _____	07/08/2016

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 441	Continued From page 45 19. If the RN needs to assess due to a change in the wound status and /or review the treatment choices, documentation should be completed on the Wound RN Assessment." The facility's Dressing Change Policy, had clearly not been followed during the dressing change and there was a potential of cross contamination of the wounds. R52's Admission Minimum Data Set dated 6/17/16, indicated R52 was moderately cognitive impaired and required assistance with bed mobility, transfers, eating and toileting. R52's face sheet indicated R52's diagnoses included prostate cancer, diabetes, and atrial fibrillation. During incontinence care observation on 7/7/16, from 9:32 a.m. until 9:45 a.m. At 9:32 a.m. Nursing assistant (NA)-B entered room and asked R52 if staff could clean him up. R52 agreed. R52 was lying on bed on his back with head of bed elevated and Wedge pillow under legs and body pillow along right side. NA-B put body pillow and wedge on floor. NA-B turned on the water in the bathroom put gloves on. NA-B opened R52's incontinent brief and wiped R52's perineal area. At 9:36 a.m. NA-A entered R52's room and put gloves on. NA-B rolled R52 onto left side. NA-A removed the incontinent brief and wiped R52's bottom. R52 had been incontinent of soft brown stool. NA-A told NA-B that there was stool on NA-B's glove. NA-A removed gloves and applied a new incontinent brief without washing or sanitizing hands. NA-B removed gloves and then without washing or sanitizing hands, helped NA-A boost R52 up in bed. They placed the wedge pillow so R52's heels were floated. R52 was lying flat on back in same position as prior to	F 441		

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 _____	07/08/2016

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 441	Continued From page 46 incontinence care was done with head of bed up 30 degrees. NA-B placed a pillow along R52 s left side and NA-A placed a pillow along R52's right side. Elbow pads were not placed on either elbow. At 9:43 a.m. NA-B and NA-A sanitized their hands prior to leaving R52's room. Neither nursing assistant washed their hands after cleaning the stool from R52's bottom. During interview on 7/7/16, at 9:50 a.m. NA-B acknowledged I should have cleaned my hands when I removed my gloves but I did not want to leave him. During interview on 7/7/16, at 9:55 a.m. NA-A acknowledged not washing or sanitizing hands after removing gloves. NA-A acknowledged there had been stool on the gloves.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/06/2016**

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	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 06, 2016. 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 St., 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		08/04/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/06/2016**

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 <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@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 25 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/06/2016**

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 018 SS=C	Continued From page 2 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3	K 018	General Disclaimer Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/06/2016**

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 018	Continued From page 3 Findings include: On the facility tour between 08:30 AM to 11:30 AM on 07/06/2016, it was observed that the corridor door to the conference room required force to open and close and did not positively latch into the frame.	K 018	response and plan of correction constitutes the facility' s allegation of compliance in accordance with section 7305 of the State Operations Manual. K018 1. Edge guard on door will be removed from the conference room door to allow door more freedom of movement and positive latching. 2. This will be completed by 8-08-16. 3. Environmental Services Director will monitor all doors to make sure all open/close/latch appropriately.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with one hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and	K 029	K-29 1. A door closure will be placed on the storage door. 2. This will be completed by 08/08/16. 3. Environmental Service Director	8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/06/2016**

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 029	Continued From page 4 doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 On the facility tour between 08:30 AM to 11:30 AM on 07/06/2016, observations revealed the following deficient condition was identified: 1) The door to the Lower Level Storage Room did not have a door closure.	K 029	or designee to monitor installation of door closure.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Findings include: On the facility tour between 08:30 AM to 11:30 AM on 07/06/2016, observations and staff interview revealed that the stairs of the exit discharge from the boiler room was packed with leaves and debris making it difficult to see the stairs.	K 038	K-38 1. Leaves and debris were immediately removed from stairwell. Stairwell checks were added to the weekly maintenance checklist. Maintenance staff or Environmental services director will monitor weekly or with a significant weather event and clean as necessary. 2. This will be completed by 8-08-16 3. Environmental Services Director of designee will monitor weekly.	8/8/16
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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	K 050		8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/06/2016**

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 050	Continued From page 5 persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Findings include: On the facility documentation review between 08:30 AM to 11:30 AM on 07/06/2016, record review revealed the facility did not properly complete the paperwork required for the fire drills form July 2015- June 2016.	K 050	K050 1. Environmental Services Director educated Maintenance Staff on proper completion of documentation of fire drills. Fire drill documentation will be reviewed for compliance at the monthly Safety Meeting. 2. This will be completed by 8-12-16. 3. Environmental Services Director or designee will review fire drill documentation on a monthly basis as drills are completed.	
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: 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	K 062	K062 1. Administrator has contracted with a new sprinkler company to conduct annual inspections. Inspection date to be added to the sprinkler company calendar to ensure timeliness of annual	8/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/06/2016**

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 062	Continued From page 6 Findings include: On the facility tour between 08:30 AM to 11:30 AM on 07/06/2016, 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 January 29, 2015 and current fire sprinkler annual test/inspection was conducted on March 01, 2016 resulting in more than a year between inspection and maintaining their system.	K 062	inspections. 2. This will be completed by 8-8-16. 3. Environmental Services Director or designee to monitor annual inspection date and communication with the inspection company.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Findings Include: On the facility tour between 08:30 AM to 11:30 AM on 07/06/2016, it was observed that the fire extinguisher's expired in June of 2016.	K 064	K064 1. Fire extinguishers were inspected on 7-31-16. New contract has been set up for annual inspections with a new fire inspection company. 2. Completion date was 7/31/16. 3. Environmental Services Director or designee to monitor for annual compliance.	8/2/16
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA	K 144		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/06/2016**

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 144	Continued From page 7 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: On the facility tour between 08:30 AM to 11:30 AM on 07/06/2016, during the review of all available documentation for the emergency generator revealed: 1) The facility did not document the required cool down for the emergency generator from November 2015 to July 2016. 2) Last date of weekly inspection was 06/23/2016 and during the interview with the Enviromental Services Manager the employee that performs the weekly checks is on a two week vacation.	K 144	K144 1. Five minute cool down of generator is now being documented. Maintenance Director educated Environmental Services Director on weekly and monthly generator checks and required documentation of checks. 2. This will be completed by 8-8-16. 3. Environmental Services Director to review generator logs on a monthly basis to assure compliance.	

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 _____	**07/06/2016**

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	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 06, 2016. 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 St., 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		08/04/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **02 - 2006 ADDITION** B. WING _____	**07/06/2016**

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 <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@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 25 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm	K 050		8/12/16

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 _____	**07/06/2016**

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 050	Continued From page 2 signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Findings include: On the facility documentation review between 08:30 AM to 11:30 AM on 07/06/2016, record review revealed the facility did not properly complete the paperwork required for the fire drills form July 2015- June 2016.	K 050	K050 1. Environmental Services Director educated Maintenance Staff on proper completion of documentation of fire drills. Fire drill documentation will be reviewed for compliance at the monthly Safety Meeting. 2. This will be completed by 8-12-16. 3. Environmental Services Director or designee will review fire drill documentation on a monthly basis as drills are completed.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		8/8/16

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 _____	**07/06/2016**

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 062	Continued From page 3 This STANDARD is not met as evidenced by: Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Findings include: On the facility tour between 08:30 AM to 11:30 AM on 07/06/2016, 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 January 29, 2015 and current fire sprinkler annual test/inspection was conducted on March 01, 2016 resulting in more than a year between inspection and maintaining their system.	K 062	K062 1. Administrator has contracted with a new sprinkler company to conduct annual inspections. Inspection date to be added to the sprinkler company calendar to ensure timeliness of annual inspections. 2. This will be completed by 8-8-16. 3. Environmental Services Director or designee to monitor annual inspection date and communication with the inspection company.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Findings include: On the facility tour between 08:30 AM to 11:30 AM on 07/06/2016, it was observed that the fire extinguisher's expired in June of 2016.	K 064	K064 1. Fire extinguishers were inspected on 7-31-16. New contract has been set up for annual inspections with a new fire inspection company. 2. Completion date was 7/31/16. 3. Environmental Services Director or designee to monitor for annual compliance.	8/2/16
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised	K 144		8/8/16

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 _____	**07/06/2016**

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 144	Continued From page 4 under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: On the facility tour between 08:30 AM to 11:30 AM on 07/06/2016, during the review of all available documentation for the emergency generator revealed: 1) The facility did not document the required cool down for the emergency generator from November 2015 to July 2016. 2) Last date of weekly inspection was 06/23/2016 and during the interview with the Environmental Services Manager the employee that performs the weekly checks is on a two week vacation.	K 144	K144 1. Five minute cool down of generator is now being documented. Maintenance Director educated Environmental Services Director on weekly and monthly generator checks and required documentation of checks. 2. This will be completed by 8-8-16. 3. Environmental Services Director to review generator logs on a monthly basis to assure compliance.	