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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4BMR

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 **10/05/2017** (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 **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(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):

Effective August 30, 2017, the four active nursing home beds are permanently decertified in accordance with the permanent delicensure of these same four beds. Effective August 30, 2017, the number of certified SNF/NF beds are 32. After this chnge they currently have 1 bed on layaway.

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 10/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/05/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245314

October 18, 2017

Ms. Kelli Guyse, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

Dear Ms. Guyse:

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 September 23, 2017 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 18, 2017

Ms. Kelli Guyse, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

RE: Project Number S5314026

Dear Ms. Guyse:

On September 13, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 10, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On October 5, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR). We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 10, 2017, effective September 23, 2017 and therefore remedies outlined in our letter to you dated September 13, 2017, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 18, 2017

Ms. Kelli Guyse, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

Re: Reinspection Results - Project Number S5314026

Dear Ms. Guyse:

On October 5, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 5, 2017, with orders received by you on September 19, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4BMR

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 **08/10/2017** (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 **32** (L18)
13.Total Certified Beds **32** (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
	32			
(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 :
Glenora Souther, HFE NE II 09/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/04/2017 (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

Electronically delivered
September 13, 2017

Ms. Kelli Guyse, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

RE: Project Number S5314026

Dear Ms. Guyse:

On August 10, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 19, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 10, 2017 (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 February 10, 2018 (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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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 _____	08/10/2017

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 On 8/7/17, through 8/10/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 154 SS=D	483.10(c)(1)(2)(iii)(4)(5) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS (c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: (c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. (c)(iii) The right to be informed, in advance, of changes to the plan of care. (c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or	F 154		9/23/17

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

Electronically Signed | 09/22/2017

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 _____ B. WING _____	08/10/2017

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 154	Continued From page 1 professional that will furnish care. (c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform 1 of 5 residents (R9), of the actions and side effects of a newly ordered medication prior to administration. Findings include: R9's Admission Record dated 7/6/17, diagnoses included diabetes, weakness, chronic pain, high blood pressure, dizziness and giddiness. The admission Minimum Data Set (MDS) dated 7/14/17, indicated R9 was cognitively intact and was moderately depressed. The Care Area Assessment (CAA) dated 7/14/17, indicated R9 had little pleasure in doing things. R9's care plan dated 7/18/17, identified a mood problem. R9's Care Conference note on 8/3/17, did not include documentation of mood or behaviors. On 8/3/17, at 6:30 p.m., licensed practical nurse (LPN)-B sent a Fax Communication to Physician form to R9's medical doctor (MD) that concluded with the statement, "Any new orders at this time?" In addition, LPN-B sent another Fax Communication to Physician form dated 8/7/17, to R9's MD documenting a conversation which had occurred with the provider the morning of 8/7/17. The same communication form included a medication order for Zoloft (a medication used to	F 154	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 allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. R9 was educated about the use and side effects of Zoloft on 8/8/17. The center will review the medical records of all current residents who have had a medication change in the last 30 days to ensure that there is documentation of education on use and side effects. If no documentation is found, then immediate education with the resident or legal representative will be done per Good Samaritan Society Medication Policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 154	Continued From page 2 treat the symptoms of depression) 25 milligrams (mg) one tablet by mouth daily for depression and was signed by the certified nurse practitioner. The fax was received on 8/7/17, at 12:06 p.m. R9's Medication Administration Record (MAR) for August 2017 indicated Zoloft 25 mg was given with R9's other morning (AM) medications. The AM medications were documented on the MAR as given on 8/8/17, at 8:00 a.m. During an interview on 8/8/17, at 8:46 a.m., R9 stated she had gotten a new pill that morning and had asked the staff what it was. R9 stated she was told that it would calm her down. R9 stated she had never seen the pill before and had not received the risk versus benefits about the medication. A Progress Note dated 8/8/17, at 1:48 p.m. noted R9 had asked about the new medication. At that time, R9 received an explanation that new medication was for depression and side effects were discussed. During an interview on 8/9/17, at 8:41 a.m., the director of nursing (DON) confirmed there was no documentation that education, including indications for use and possible side effects of the prescribed medication, had been provided to R9 prior to Zoloft administration. The DON stated she expected resident education to occur prior to the administration of the first dose. The DON confirmed Zoloft was administered prior to R9 receiving information about the use and side effects of that medication. A Medication Policy revised 12/15, indicated "education will be provided to the resident	F 154	Licensed nurses were re-educated by DON on facility□s Medications Policy on 9/13/17. Education provided was when there is a medication change, prior to administration, education will be provided by licensed nurses or the provider to the resident and/or legal representative regarding safe and effective use of medication when applicable in accordance with resident needs and legal requirements. Record review audits will be conducted by Nurse Manager or designee weekly X4, bi-monthly X 1 and then monthly X 2 to ensure all residents with medication changes have education provided regarding safe and effective use and side effects of the medication prior to administration and education documented. Audit results will be reviewed by QAPI committee for further recommendation.	

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F 154	Continued From page 3 regarding safe and effective use of medications." The policy did not indicate when the education would be provided.	F 154		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self-administration of medications was safe for 1 of 1 resident (R19) observed to self-administer a nebulizer treatment during a random observation Findings include: R19's Resident Self-Administration of Medications assessment dated 4/26/17, indicated R19 had significantly impaired memory and limitation in communication. Assessment indicated R19 was cooperative and able to understand that nebulizer mask needs to stay on until complete. Assessment indicated teaching was provided to R19 regarding medication and proper placement of mask and the outcome of the teaching was staff were to provide prompts to leave mask on during treatment. Determination of interdisciplinary team was documented on assessment as "Resident able to self administer SOME medications Specify medications resident is able to safely self-administer: DuoNeb [an inhaled medication that relaxes airways and makes it easier to breath] Solution 0.5 to 2.5 Mg	F 176	Nursing staff were instructed on 8/8/17 to stay with R19 while resident is receiving DuoNeb solution via nebulizer. The center will review the medical records of all current residents self-administering medications to ensure they have been assessed to be safe self-administering, have an order to self-administer, and have this included in their care plan. If any of these factors are missing, then immediate action will be taken to correct and residents will not be left to self-administer during the time it takes to correct. Licensed nurses will be re-educated by DON on Resident Self-Administration of Medication Procedure. When a resident wants to self-administer, they will be assessed to be safe, an order will be obtained, and it will be care planned for. Record review audits will be conducted by DON or designee weekly X 4, bi-monthly X 1 and then monthly X 2 to ensure all residents self-administering medications	9/23/17

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F 176	Continued From page 4 [Milligram]/ 3 ML [milliliter] every 4 hrs [hours] as needed. Able to leave mask on for nebulizer treatment." R19's quarterly Minimum Data Set (MDS) dated 5/3/17, indicated R19 was severely cognitively impaired, had no limitations in range of motion and required supervision with eating. On 8/8/17, at 10:42 a.m. during a random observation a nebulizer machine was heard run from outside the hallway. Upon knocking at the door and going into the room R19 was observed sitting up in Broda chair wearing a face mask with a nebulizer chamber on it. There was solution in the chamber. R19 brought his right hand up to the right side of the mask and pushed on it but did not dislodge it. Resident was not able to say what the mask was for. Review of August Medication Record indicated the medication R19 was receiving was Duo Neb solution 0.5-2.5 3 mg/3 ml one vial via nebulizer three times a day for acute upper respiratory infection. Review of care plan printed 8/10/17, revealed care plan did not address self-administration. The Medication Review Report printed 8/10/17, indicated R19 was to receive DuoNeb solution 0.5-2.5 3 mg/3 ml one vial via nebulizer scheduled three times a day and as needed every four hours for upper respiratory infection. During interview on 8/8/17, at 1:58 p.m. licensed practical nurse (LPN)-C stated R19 did not have a self-administration order. LPN-C stated she would set R19 nebulizer and then would come	F 176	going forward have been assessed to be safe, have an order, and it is care planned for. Audit results will be reviewed by QAPI committee for further recommendation.	

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F 176	Continued From page 5 back occasionally to see if it was done. LPN-C said, "I do not believe we have to sit with him when he is getting his neb." LPN-C verified R19 was receiving his scheduled DuoNeb not the as needed dose. During interview on 8/9/17, at 1:30 p.m. the director of nursing verified R19 did not have an order or care plan to self-administer any medication. Resident Self-Administration of Medication procedure revised 7/14, instructed staff: "7. A physicians order must be obtained prior to the resident self-administering medications. The order must be specific to the medication being self-administered. 8. The care plan must indicate which medications the resident is self-administering, where they are kept, who will document the medication and the location of administration, if applicable."	F 176		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of	F 278		9/23/17

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F 278	Continued From page 6 that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Minimum Data Set (MDS) was accurately coded for 2 of 2 residents (R13, R16) Findings include: R13's Hospital Long Term Care Discharge Form signed 4/17/17, indicated R13 had been admitted to the hospital from 4/14/17, through 4/17/17, with a primary diagnosis of urinary tract infection and secondary diagnosis of acute renal failure, diabetes and high blood pressure. Discharge Summary dated 4/17/17, indicated acute kidney injury attributed to dehydration (when the body loses more fluids then it takes in) that resolved during hospitalization with	F 278	R16 no longer has an open wound, considered healed by FNP/wound nurse on 9/11/17. R13 no longer resides in facility. MDS□s have been corrected as appropriate. All of the most recent MDS□s of current residents with diagnosis of dehydration and diabetic ulcers have been reviewed and corrected if found to be inaccurate. MDS Coordinator was re-educated by Good Samaritan Society□s Clinical Compliance Consultant on appropriate coding for these diagnoses. Residents with diagnosis of dehydration and/or diabetic ulcers will have MDS□s	

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F 278	Continued From page 7 intravenous (IV) fluids. R13 was discharged to nursing home because R13 required nine more days of IV antibiotics to treat a urinary tract infection. R13's admission Minimum Data Set (MDS) dated 4/24/17, indicated R13 was dehydrated during the seven-day look back period of 4/18/17 through 4/24/17. Review of vital signs revealed no abnormalities in temperature, pulse or blood pressure. Review of progress notes from 4/17/17 through 4/27/17, lacked documentation of any symptoms of dehydration or monitoring of fluid intake. R13's dehydration care area assessment (CAA) dated 4/27/17, indicated R13 was admitted with the diagnosis of dehydration based on lab results from hospitalization. CAA indicated R13 was not showing signs of dehydration at time of MDS. CAA indicated, "Since there are no s/s [signs or symptoms] of dehydration will not care plan a focus for such." During interview on 8/10/17, at 10:17 a.m. the director of nurses (DON) stated the hospital admission note dated 4/14/17, indicated R13 was admitted to the hospital for dehydration and was being treated for urinary tract infection. The DON stated that at time of admission to facility dehydration was resolved and there was no monitoring of symptoms of dehydration being done. The DON stated the MDS was inaccurate. The October 2016, MDS 3.0 Resident Assessment manual instructs staff regarding dehydration, "Dehydrated: Check this item if the resident presents with two or more of the following potential indicators for dehydration:	F 278	audited by DON or designee bi-monthly X 1 and monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation.	

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F 278	Continued From page 8 1. Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards. 2. Resident has one or more potential clinical signs (indicators) of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity). 3. Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement)." R16's Physician Progress Note dated 4/10/17, identified current diagnosis to include, diabetic ulcer (Ulcers caused by the neuropathic (nerve) and small blood vessel complications of diabetes.) of left heel, non-pressure chronic ulcer of unspecified heel and mid-foot with unspecified severity, peripheral artery disease (narrowing and hardening of blood vessels that carry blood from the heart to the legs and feet), and chronic peripheral venous insufficiency (inability of veins to pump blood from feet and legs back to the heart). R16's annual MDS dated 4/19/17, indicated R16 had an unhealed pressure ulcer that was unstageable due to coverage of wound bed by slough or eschar. The MDS did not indicate R16 had a diabetic foot ulcer.	F 278		

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F 278	Continued From page 9	F 278		

R16's Physician Progress Note 5/22/17, documented left heel wound open area a 2.5 cm. x 2.3 cm. Wound was superficial 75% granular and edges were flat and macerated. Surrounding skin was intact. Active diagnoses were diabetic ulcer of left heel, and non-pressure chronic ulcer of unspecified heel and mid-foot with unspecified severity, peripheral artery disease, and Chronic Peripheral venous insufficiency.

R16's Quarterly MDS dated 7/20/17, indicated R16 had an unhealed pressure ulcer that was unstageable due to eschar due to coverage of wound bed by slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture.) or eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound). The MDS did not indicate R16 had a diabetic foot ulcers.

During interview on 8/9/17, at 7:45 a.m. R16 was sitting in recliner leaning to the right side. There were ace wraps on both legs from foot to mid-calf, with black socks and square tipped shoes over the ace wraps. R16 stated he had a wound on his heel that has been there for a long time. R16 said, "The doctors told me the wound on my heel is due to my diabetes and terrible circulation. I am to avoid sweets follow my diet, take my medications, make sure I have shoes on when out of bed, wear the ace wraps during the day and elevate my feet when able."

During observation of lower extremity wound care on 8/9/17, at 9:02 a.m. licensed practical nurse

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F 278	Continued From page 10 (LPN)-A removed R16's left shoe, sock and ace wrap. The skin of R16's left leg was discolored. Upper calf and shin red to purple red and lower leg brown down to the ankle. R16's left heel and foot covered with gauze. LPN-A donned gloves and cut gauze dressing off the foot. There was yellow brown drainage visible on the gauze. LPN-A removed gloves and put on a new pair of gloves without washing hands or using alcohol based sanitizer. LPN-A sprayed wound cleanser on gauze and cleaned left heel wound. LPN-A measured R16's left heel wound. The periwound area was 7 centimeters (cm.) long by 9 cm. wide with a superficial open area in the middle measuring 2 cm. x 2.5 cm. The top of the second and third toes were black. LPN-A completed the dressing of R16's foot and reapplied the ace wraps. During interview on 8/10/17, at 1:31 p.m. the DON reviewed R16's annual MDS dated 4/19/17, and quarterly MDS dated 7/20/17. DNS verified both MDS's were coded indicating R16 had unhealed pressure ulcers staged as unstageable pressure ulcer covered with eschar or slough. The DON stated both MDSs' were miscoded because R16 did not have a pressure ulcer on April 19, or July 20. The DON verified diabetic foot ulcers were not coded on the MDS. The DON said, "I expect the MDSs' to be accurate."	F 278		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 431		9/23/17

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F 431	Continued From page 11	F 431		

law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. 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.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of

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F 431	Continued From page 12 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an insulin pen (medication to control blood sugar) was labeled appropriately prior to administration for 1 of 1 resident (R9) reviewed who used insulin. In addition, the facility failed to properly secure medications for 1of 1 resident (R38) who did not wish to self-administer medication. Findings include: During medication storage observation on 8/7/17, at 8:07 p.m., a Tresiba Flextouch pen (an injectable medication for the treatment of diabetes) was observed in the top drawer of the nurse's medication cart that did not have a pharmacy label or facility resident label. There was no date opened written on the pen. R9's admission record dated 7/6/17, indicated R9 had a diagnosis of type 2 diabetes. R9's order summary printed 7/6/17, indicated R9 was to receive Tresiba Flextouch 44 units every 24 hours. During an interview on 8/7/17, at 8:07 p.m., with licensed practical nurse (LPN)-C verified R9's Tresiba Flextouch pen did not have a pharmacy label, facility label and had not been dated when opened. LPN-C stated that the insulin pen was	F 431	All of R9□s insulin pens were sent back to pharmacy to be properly labeled on 8/8/17. R38□s inhaler was removed from resident□s room and stored in the med room on 8/8/17. R38 has since discharged. All current resident medications were reviewed by consultant pharmacist on 9/11/17 to ensure proper labeling and storage. Pharmacy was made aware of the labeling error on 8/8/17 and was re-educated by DON on 9/15/17 of this deficiency in order to ensure continued compliance. Licensed nurses were re-educated by DON on 9/13/17 of the need to have the individual insulin pens labeled and to send similar errors back to pharmacy for labeling before administering. Nursing staff will be educated on the need to inform charge nurse of medications found in resident rooms. 2 resident rooms will be audited for medications by DON or designee weekly X 4, bi-monthly x 1, and monthly X 2. Medications will be audited for proper	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 opened and used that evening for supper. LPN-C further indicated that the facility pharmacy affixed the label on the box, not on the insulin pens and that the nurses labeled the insulin pen using the facility label. LPN-C placed a facility sticker on R9's Tresiba Flextouch pen. During an interview on 8/10/17, at 12:34 p.m., when asked about the expectations of having labels on insulin pens, the pharmacist said "there should be some kind of labeling on it, that would be the minimal requirement." During an interview on 8/10/17, at 3:06 p.m., the director of nursing (DON) indicated if medications were not labeled the facility would send it back to pharmacy, she said "that's what we did for the Tresiba." DON further indicated the insulin pen should have been labeled. Good Samaritan Society-Winthrop policy dated 9/2016, for "Acquisiting, Receiving, Dispensing and Storage of Medications" indicated "All medications are packaged in accordance with the location dispensing system and state pharmacy rules. These medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied by the pharmacist or the pharmacist's agent as needed." R38's Admission Face Sheet dated 8/3/17, indicated diagnoses of chronic obstructive pulmonary disease. R38's Nursing Admit Data Collection dated 8/3/17, indicated R38 did not want to self-administer her medications and that she did not bring any medications from home.	F 431	labeling weekly X 4, bi-monthly X 1, and monthly X 2. Audit results will be reviewed by QAPI committee for further recommendation.	

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	245314	A. BUILDING _____ B. WING _____	08/10/2017

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F 431	Continued From page 14 R38's doctor's orders dated 8/3/17, included Symbicort Aerosol 80-4.5mcg/ACT inhaler two puffs inhaled every twelve hours as needed for chronic obstructive pulmonary disease. R38's medication administration record for August 2017, indicated that Symbicort was not administered to R38. During a random observation on 8/8/17, at 8:46 a.m. an inhaler was seen on the dresser in R38's room in plain sight. A follow up observation on 8/8/17, at approximately 9:30 a.m. the inhaler was in the same exact spot. During interview on 8/8/17, at approximately 9:30 a.m. with licensed practical nurse (LPN)-C picked up the inhaler and stated that R38 must have had the inhaler in her personal items from the hospital. LPN-C stated that she was not sure if R38 was able to self-administer medications or if R38 had used the inhaler. LPN-C removed the inhaler from R38's room and placed it in the medication room. On 8/9/17, at 8:31 a.m. during interview LPN-A stated on admission all resident belonging was checked for any medications that are brought in with the resident. LPN-A stated the policy for medication storage indicates that staff was to bring all medications found in the resident room needs to be brought to the charge nurse to be locked in the medication room. LPN-A stated that inhaler should have been locked in the medication room when it was found by the staff.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		9/23/17

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F 441	Continued From page 15 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		

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F 441	Continued From page 16 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide proper hand hygiene and glove usage for 1 of 1 resident (R16) observed for wound care. In addition, the facility failed to ensure a resident had a covered and cleanable positioning device for 1 of 1 resident (R6) reviewed for positioning devices in the wheelchair. Findings include: During observation of lower extremity wound care	F 441	R16; upon surveyor bringing hand hygiene issue to DON□s attention, immediate re-education was provided to nurse on 8/10/17. R6□s uncovered egg carton foam cushion was removed and replaced with an appropriate pressure relieving covered cushion on 8/10/17 by DON. There are no current residents in the center with an open wound. All current residents were observed for uncovered	

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F 441	Continued From page 17 on 8/9/17, at 9:02 a.m. licensed practical nurse (LPN)-A removed R16's right shoe and ace wrap. LPN-A put on gloves and opened a new container of Replenishing Skin cream. LPN-A dipped gloved hand into container and applied cream to right foot and lower leg. The right fourth toe nail was black. Without changing gloves LPN-A dipped gloved hand into container of cream and put cream on R16's right arm at R16's request. LPN-A removed gloves and applied ace wrap to right leg from the toes to below R16's knee. LPN-A put R16's right sock and shoe on. Without washing or using an alcohol based sanitizer LPN-A removed R16's left shoe, sock and ace wrap. The skin of R16's left leg was discolored. Upper calf and shin red to purple red and lower leg brown down to the ankle. R16's left heel and foot covered with gauze. LPN-A put gloves on and cut gauze dressing off the foot. There was yellow brown drainage visible on the gauze. LPN-A removed gloves and put on a new pair of gloves without washing hands or using alcohol based sanitizer. LPN-A sprayed wound cleanser on gauze and cleaned left heel wound. with the same gloves on LPN-A measured R16's left heel wound. The periwound area was 7 centimeters (cm.) long by 9 cm. wide with a superficial open area in the middle measuring 2 cm. x 2.5 cm. The top of the second and third toes were black Without changing gloves or washing hands LPN-A opened package of Kerlix and a package of gauze. LPN-A put medi honey on the gauze and placed gauze over the open area on the heel. LPN-A then wrapped R16's heel and foot with Kerlix and then removed gloves. LPN-A put the extra gauze and medi honey away in R16's closet and taped the Kerlix. LPN-A wrapped R16's foot and lower leg with an ace wrap and put R16's left sock and shoe on. Without washing hands LPN-A	F 441	cushions. All cushions are appropriate and no egg carton foam cushions in use. Licensed nurses will be re-educated by DON or designee on Good Samaritan Society□s policy and procedure for Hand Hygiene and Hand Washing and wound care to ensure infection control practices are followed. Nursing staff will be re-educated on 9/20 and 9/21 on proper cushion use to ensure infection control practices are followed. Observation audits will be conducted by DON or designee of 2 licensed nurse treatments weekly X 4, bi-monthly X 1, and monthly X 1. 3 wheelchair cushion audits will be conducted bi-monthly X 2 and monthly X 2. Audit results will be reviewed by QAPI committee for further recommendation.	

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F 441	Continued From page 18	F 441		

gathered the trash and exited R16's room and went to utility room and threw the trash away. LPN then went to the employee bathroom and wash her hands.

During interview on 8/9/17, at 9:18 a.m. LPN-A verified not use hand sanitizer or wash hands when she changed her gloves. LPN-A acknowledged using her glove to get cream out of container for R16's arm with the same glove she used for his leg and foot.

During interview on 8/10/17, at 1:23 p.m. the director of nurses (DON) stated when staff use gloves to take a dressing off the gloves are are considered dirty and before putting on a new dressing on a resident the staff need to remove their gloves, wash their hands and put on clean gloves. The DON stated staff can put a hand covered with a clean glove into a container, but cannot go into container with a glove that has touched skin. The DON said, "I expect staff to wash hands when they remove gloves."

Hand Hygiene and Handwashing procedure revised 3/16, instructed staff, "If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands: ... After removing gloves. Note: Alternatively, hands may be washed with an anti-microbial soap and water in clinical situations described above.

R6's Admission Face Sheet, 5/27/15, indicated diagnoses of dementia, chronic pain, osteoarthritis, and muscle weakness. R6 was started on hospice 6/23/17.

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F 441	Continued From page 19	F 441		

R6's significant change Minimum Data Set (MDS), dated 7/7/17, indicated R6 required extensive assistance with locomotion in a wheelchair. MDS further indicated R6 had moderate cognitive impairment.

R6's Care Area Assessment (CAA) dated 7/21/17, for activities of daily living indicated physical limitations for locomotion due to limited range of motion, weakness, and poor balance. CAA for pressure ulcer indicated R6 would be at increased risk for pressure ulcers as she declines and had a cushion in her wheelchair for prevention.

During observation on 8/9/17, at 7:56 a.m. R6 was sitting in wheelchair for transport and was transferred to easy chair. It was noted that there was an uncovered egg carton foam cushion approximately three inches thick on the seat of the wheelchair. At 10:36 a.m. on 8/9/17, R6 was transferred into the wheelchair with the same cushion on the seat and transported to her room, at 10:45 a.m. R6 remained sitting in the wheelchair with the same cushion. The cushion was not covered and rendered it uncleanable.

During interview with nursing assistant (NA)-A on 8/10/17, at 8:59 a.m. NA-A stated that she did not know when the cushion was placed in the wheelchair, but stated it had been in there for a while. NA-A also stated that she did not know why the cushion was in the wheelchair, because they did not use that kind of cushion.

At 9:31 a.m. on 8/10/17, the director of nursing (DON) checked the wheelchair cushion and stated that it was not a cushion the facility supplied. DON stated the cushions are usually

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F 441	Continued From page 20 covered and not just foam. DON stated she did not know where the cushion came from. During an interview on 8/10/17, at 9:40 a.m. with the hospice RN case manager (CM) it was revealed cushions supplied by hospice are a covered gel cushion and hospice had not supplied a wheelchair cushion. During interview with the DON on 8/10/17, at 9:58 a.m. the DON was asked "what is the procedure for cushions like the cushion in the R6's wheelchair?" DON stated, "I would throw it away. We don't use those cushions here." DON again stated she did not know where the cushion came from.	F 441		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain flooring and walls in the kitchen. Findings include:	F 465	Tiles were replaced on 9/22/17 in order to provide a safe, cleanable surface. Other tiled walls in facility were inspected by maintenance on 9/22/17 and all were	9/23/17

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F 465	Continued From page 21 During tour of the kitchen on 8/8/17, at 8:49 a.m. observation revealed a 4-inch x 4-inch tile cracked in half and missing with adhesive exposed on the floor next to entrance to the kitchen and outside the walk in cooler. The exposed adhesive was not a cleanable surface. On 8/10/17, at 11:40 a.m. observation revealed a 4-inch x 4-inch tile cracked in half with adhesive exposed on the floor next to entrance to the dish room. During an interview on 8/10/17, at 11:40 a.m. the director of maintenance (DM) verified the three tiles were broken. The DM stated that he was looking for replacement tiles and has been aware of the broken tiles for about two weeks. Also observed an approximately 1.5" (inches) x (by) 30" area on wall above the clean dish drying space in the dish room was missing. The DM stated he needed to replace the piece that fell off. He stated he was verbally notified of items that need to be repaired by the staff and did not have a written log. Good Samaritan Policy and Procedure for Common Area Cleaning reviewed. Document stated "All Society locations will have written, location-specific procedures for cleaning and maintaining common areas." A facility maintenance policy was requested, but not received.	F 465	deemed to be safe, cleanable surfaces. All staff received education to use the maintenance log for safety, environmental, and functionality concerns in order to ensure follow-up is completed. Record review audits will be conducted by administrator or designee of maintenance log bi-monthly X 2, and monthly X 2 in order to ensure log is being utilized and follow-up is being completed timely. Audit results will be reviewed by QAPI committee for further recommendation.	

Electronically delivered
September 13, 2017

Ms. Kelli Guyse, Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5314026

Dear Ms. Guyse:

The above facility was surveyed on August 7, 2017 through August 10, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233 or at kathryn.serie@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

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	00961	A. BUILDING: _____ B. WING _____	08/10/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/7/17, through 8/10/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		9/23/17

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2 302	Continued From page 3 Based on interview and document review, the facility failed to provide staff training for Alzheimer's and related dementia education. Findings include: On 8/9/17, at 10a.m. the director of nurses (DON) provided documentation sheets showing staff who had completed dementia training between 1/1/2016, and 8/8/2017. The DON stated staff are being slow this year completing the training but have until 12/31/17, to have the training completed. Review of sheets indicated no documentation for 37 employees out of 53 current employees. On 8/10/2017, at 2:41 p.m. the DON stated the staff training was provided with dementia/Alzheimer's training annually and upon hire. The DON was unable to explain lack of documentation, for 37 out of 53 staff members hired prior to 1/1/17, for completion of Alzheimer's training in 2016 or 2017. The administrator stated all staff members hired after 1/1/17, had completed training. The DON stated they have recently hired a new staff development nurse that they will share with another facility. Review of the facility information provided from CMS 672 revealed the facility had ten residents diagnosed with dementia at the start of the survey. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could in-service all direct care staff and their supervisors on how to work with persons with dementia type behavior. This should at a minimum include explanation of Alzheimer ' s disease and related disorders, assistance with activities of daily living, problem	2 302	corrected	

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2 302	Continued From page 4 solving with challenging behaviors and communication skills. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 302		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced	21390		9/23/17

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21390	Continued From page 5 by: Based on observation, interview, and document review, the facility failed to provide proper hand hygiene and glove usage for 1 of 1 resident (R16) observed for wound care. In addition, the facility failed to ensure a resident had a covered and cleanable wheelchair cushion for 1 of 1 resident (R6) reviewed for positioning devices in the wheelchair. Findings include: During observation of lower extremity wound care on 8/9/17, at 9:02 a.m. licensed practical nurse (LPN)-A removed R16's right shoe and ace wrap. LPN-A put on gloves and opened a new container of Replenishing Skin cream. LPN-A dipped gloved hand into container and applied cream to right foot and lower leg. The right fourth toe nail was black. Without changing gloves LPN-A dipped gloved hand into container of cream and put cream on R16's right arm at R16's request. LPN-A removed gloves and applied ace wrap to right leg from the toes to below R16's knee. LPN-A put R16's right sock and shoe on. Without washing or using an alcohol based sanitizer LPN-A removed R16's left shoe, sock and ace wrap. The skin of R16's left leg was discolored. Upper calf and shin red to purple red and lower leg brown down to the ankle. R16's left heel and foot covered with gauze. LPN-A put gloves on and cut gauze dressing off the foot. There was yellow brown drainage visible on the gauze. LPN-A removed gloves and put on a new pair of gloves without washing hands or using alcohol based sanitizer. LPN-A sprayed wound cleanser on gauze and cleaned left heel wound. with the same gloves on LPN-A measured R16's left heel wound. The periwound area was 7 centimeters (cm.) long by 9 cm. wide with a superficial open	21390	corrected	

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area in the middle measuring 2 cm. x 2.5 cm. The top of the second and third toes were black Without changing gloves or washing hands LPN-A opened package of Kerlix and a package of gauze. LPN-A put medi honey on the gauze and placed gauze over the open area on the heel. LPN-A then wrapped R16's heel and foot with Kerlix and then removed gloves. LPN-A put the extra gauze and medi honey away in R16's closet and taped the Kerlix. LPN-A wrapped R16's foot and lower leg with an ace wrap and put R16's left sock and shoe on. Without washing hands LPN-A gathered the trash and exited R16's room and went to utility room and threw the trash away. LPN then went to the employee bathroom and wash her hands.

During interview on 8/9/17, at 9:18 a.m. LPN-A verified not use hand sanitizer or wash hands when she changed her gloves. LPN-A acknowledged using her glove to get cream out of container for R16's arm with the same glove she used for his leg and foot.

During interview on 8/10/17, at 1:23 p.m. the director of nurses (DON) stated when staff use gloves to take a dressing off the gloves are are considered dirty and before putting on a new dressing on a resident the staff need to remove their gloves, wash their hands and put on clean gloves. The DON stated staff can put a hand covered with a clean glove into a container, but cannot go into container with a glove that has touched skin. The DON said, "I expect staff to wash hands when they remove gloves."

Hand Hygiene and Handwashing procedure revised 3/16, instructed staff, "If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for

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routinely cleaning hands: ... After removing gloves. Note: Alternatively , hands may be washed with an anti-microbial soap and water in clinical situations described above.

R6's Admission Face Sheet, 5/27/15, indicated diagnoses of dementia, chronic pain, osteoarthritis, and muscle weakness. R6 was started on hospice 6/23/17.

R6's significant change Minimum Data Set (MDS), dated 7/7/17, indicated R6 required extensive assistance with locomotion in a wheelchair. MDS further indicated R6 had moderate cognitive impairment.

R6's Care Area Assessment (CAA) dated 7/21/17, for activities of daily living indicated physical limitations for locomotion due to limited range of motion, weakness, and poor balance. CAA for pressure ulcer indicated R6 would be at increased risk for pressure ulcers as she declines and had a cushion in her wheelchair for prevention.

During observation on 8/9/17, at 7:56 a.m. R6 was sitting in wheelchair for transport and was transferred to easy chair. It was noted that there was an uncovered egg carton foam cushion approximately three inches thick on the seat of the wheelchair. At 10:36 a.m. on 8/9/17, R6 was transferred into the wheelchair with the same cushion on the seat and transported to her room, at 10:45 a.m. R6 remained sitting in the wheelchair with the same cushion. The cushion was not covered and rendered it uncleanable.

During interview with nursing assistant (NA)-A on 8/10/17, at 8:59 a.m. NA-A stated that she did not

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21390	Continued From page 8 know when the cushion was placed in the wheelchair, but stated it had been in there for a while. NA-A also stated that she did not know why the cushion was in the wheelchair, because they did not use that kind of cushion. At 9:31 a.m. on 8/10/17, the director of nursing (DON) checked the wheelchair cushion and stated that it was not a cushion the facility supplied. DON stated the cushions are usually covered and not just foam. DON stated she did not know where the cushion came from. During an interview on 8/10/17, at 9:40 a.m. with the hospice RN case manager (CM) it was revealed cushions supplied by hospice are a covered gel cushion and hospice had not supplied a wheelchair cushion. During interview with the DON on 8/10/17, at 9:58 a.m. the DON was asked "what is the procedure for cushions like the cushion in the R6's wheelchair?" DON stated, "I would throw it away. We don't use those cushions here." DON again stated she did not know where the cushion came from. SUGGESTED METHOD OF CORRECTION: The facility DON or infection control nurse could review and revise policies and procedures in relation to the facility's infection control program. Education could be provided as appropriate. Audits could be conducted. The director of nursing (DON) or designee could develop, review, and/or revise Infection Control program and ensure that resident and staff infections are monitored and analyzed. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21390		

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Mantoux testing was completed for 1 of 5 residents (R1). Findings include: A review of R1's medical record indicated she was admitted to the facility on 6/20/17. The Medical record lacked evidence of a symptom screen, as well as documentation of a two-step TB (tuberculin) skin test.	21426	corrected	9/23/17

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21426	Continued From page 10 During an interview on 8/10/17, at 3:06 p.m., the director of nursing (DON) stated R1 was admitted from another facility and stated she would have to find out where R1's Mantoux records were. DON further indicated that TB screening was done upon admission to the facility as part of the admission order set. R1's TB symptoms screen and Mantoux skin tests were requested and no records were provided from the facility. Suggested Method for Correction: The administrator or designee could review the facility system in place to ensure newly admitted residents receive screening of TB symptoms and the TST as required by state rule. Revise the system as needed and educate staff on the system in place. Monitor and review the delivery of the TST and adjust the system as needed. Time Period for Correction: Twenty one (21) days	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly secure medications for 1of 1 resident (R38) who did not wish to self-administer medication.	21610	corrected	9/23/17

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21610	Continued From page 11 Findings include: R38's Admission Face Sheet dated 8/3/17, indicated diagnoses of chronic obstructive pulmonary disease. R38's Nursing Admit Data Collection dated 8/3/17, indicated R38 did not want to self-administer her medications and that she did not bring any medications from home. R38's doctor's orders dated 8/3/17, included Symbicort Aerosol 80-4.5mcg/ACT inhaler two puffs inhaled every twelve hours as needed for chronic obstructive pulmonary disease. R38's medication administration record for August 2017, indicated that Symbicort was not administered to R38. During a random observation on 8/8/17, at 8:46 a.m. an inhaler was seen on the dresser in R38's room in plain sight. A follow up observation on 8/8/17, at approximately 9:30 a.m. the inhaler was in the same exact spot. During interview on 8/8/17, at approximately 9:30 a.m. with licensed practical nurse (LPN)-C picked up the inhaler and stated that R38 must have had the inhaler in her personal items from the hospital. LPN-C stated that she was not sure if R38 was able to self-administer medications or if R38 had used the inhaler. LPN-C removed the inhaler from R38's room and placed it in the medication room. On 8/9/17, at 8:31 a.m. during interview LPN-A stated on admission all resident belonging was checked for any medications that are brought in with the resident. LPN-A stated the policy for	21610		

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21610	Continued From page 12 medication storage indicates that staff was to bring all medications found in the resident room needs to be brought to the charge nurse to be locked in the medication room. LPN-A stated that inhaler should have been locked in the medication room when it was found by the staff. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to monitor medication storage. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an insulin pen (medication to control blood sugar) was labeled appropriately prior to administration for 1 of 1 resident (R9) reviewed who used insulin. Findings include: During medication storage observation on 8/7/17, at 8:07 p.m., a Tresiba Flextouch pen (an injectable medication for the treatment of diabetes) was observed in the top drawer of the nurse's medication cart that did not have a	21620	corrected	9/23/17

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21620	Continued From page 13 pharmacy label or facility resident label. There was no date opened written on the pen. R9's admission record dated 7/6/17, indicated R9 had a diagnosis of type 2 diabetes. R9's order summary printed 7/6/17, indicated R9 was to receive Tresiba Flextouch 44 units every 24 hours. During an interview on 8/7/17, at 8:07 p.m., with licensed practical nurse (LPN)-C verified R9's Tresiba Flextouch pen did not have a pharmacy label, facility label and had not been dated when opened. LPN-C stated that the insulin pen was opened and used that evening for supper. LPN-C further indicated that the facility pharmacy affixed the label on the box, not on the insulin pens and that the nurses labeled the insulin pen using the facility label. LPN-C placed a facility sticker on R9's Tresiba Flextouch pen. During an interview on 8/10/17, at 12:34 p.m., when asked about the expectations of having labels on insulin pens, the pharmacist said "there should be some kind of labeling on it, that would be the minimal requirement." During an interview on 8/10/17, at 3:06 p.m., the director of nursing (DON) indicated if medications were not labeled the facility would send it back to pharmacy, she said "that's what we did for the Tresiba." DON further indicated the insulin pen should have been labeled. Good Samaritan Society-Winthrop policy dated 9/2016, for "Acquisiting, Receiving, Dispensing and Storage of Medications" indicated "All medications are packaged in accordance with the location dispensing system and state pharmacy rules. These medications must be labeled	21620		

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21620	Continued From page 14 according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied by the pharmacist or the pharmacist's agent as needed." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure accurate medication labels, medications dated when opened, and destruction of controlled substances. The director of nursing could educate nursing staff. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview and document review the facility failed to maintain flooring and walls in the kitchen. Findings include: During tour of the kitchen on 8/8/17, at 8:49 a.m.	21685	corrected	9/23/17

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21685	Continued From page 15 observation revealed a 4-inch x 4-inch tile cracked in half and missing with adhesive exposed on the floor next to entrance to the kitchen and outside the walk in cooler. The exposed adhesive was not a cleanable surface. On 8/10/17, at 11:40 a.m. observation revealed a 4-inch x 4-inch tile cracked in half with adhesive exposed on the floor next to entrance to the dish room. During an interview on 8/10/17, at 11:40 a.m. the director of maintenance (DM) verified the three tiles were broken. The DM stated that he was looking for replacement tiles and has been aware of the broken tiles for about two weeks. Also observed an approximately 1.5" (inches) x (by) 30" area on wall above the clean dish drying space in the dish room was missing. The DM stated he needed to replace the piece that fell off. He stated he was verbally notified of items that need to be repaired by the staff and did not have a written log. Good Samaritan Policy and Procedure for Common Area Cleaning reviewed. Document stated "All Society locations will have written, location-specific procedures for cleaning and maintaining common areas." A facility maintenance policy was requested, but not received. SUGGESTED METHOD OF CORRECTION: The administrator could in-service employees who do kitchen repair. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21685		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21825	Continued From page 16	21825		
21825	MN St. Statute 144.651 Subd. 9 Patients & Residents of HC Fac.Bill of Rights Subd. 9. Information about treatment. Residents shall be given by their physicians complete and current information concerning their diagnosis, treatment, alternatives, risks, and prognosis as required by the physician's legal duty to disclose. This information shall be in terms and language the residents can reasonably be expected to understand. Residents may be accompanied by a family member or other chosen representative, or both. This information shall include the likely medical or major psychological results of the treatment and its alternatives. In cases where it is medically inadvisable, as documented by the attending physician in a resident's medical record, the information shall be given to the resident's guardian or other person designated by the resident as a representative. Individuals have the right to refuse this information. Every resident suffering from any form of breast cancer shall be fully informed, prior to or at the time of admission and during her stay, of all alternative effective methods of treatment of which the treating physician is knowledgeable, including surgical, radiological, or chemotherapeutic treatments or combinations of treatments and the risks associated with each of those methods. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to inform 1 of 5 residents	21825	corrected	9/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00961	A. BUILDING: _____ B. WING _____	08/10/2017

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21825	Continued From page 17 (R9), of the actions and side effects of a newly ordered medication prior to administration. Findings include: R9's Admission Record dated 7/6/17, diagnoses included diabetes, weakness, chronic pain, high blood pressure, dizziness and giddiness. The admission Minimum Data Set (MDS) dated 7/14/17, indicated R9 was cognitively intact and was moderately depressed. The Care Area Assessment (CAA) dated 7/14/17, indicated R9 had little pleasure in doing things. R9's care plan dated 7/18/17, identified a mood problem. R9's Care Conference note on 8/3/17, did not include documentation of mood or behaviors. On 8/3/17, at 6:30 p.m., licensed practical nurse (LPN)-B sent a Fax Communication to Physician form to R9's medical doctor (MD) that concluded with the statement, "Any new orders at this time?" In addition, LPN-B sent another Fax Communication to Physician form dated 8/7/17, to R9's MD documenting a conversation which had occurred with the provider the morning of 8/7/17. The same communication form included a medication order for Zoloft (a medication used to treat the symptoms of depression) 25 milligrams (mg) one tablet by mouth daily for depression and was signed by the certified nurse practitioner. The fax was received on 8/7/17, at 12:06 p.m. R9's Medication Administration Record (MAR) for August 2017 indicated Zoloft 25 mg was given with R9's other morning (AM) medications. The AM medications were documented on the MAR as given on 8/8/17, at 8:00 a.m. During an interview on 8/8/17, at 8:46 a.m., R9 stated she had gotten a new pill that morning and	21825		

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21825	Continued From page 18 had asked the staff what it was. R9 stated she was told that it would calm her down. R9 stated she had never seen the pill before and had not received the risk versus benefits about the medication. A Progress Note dated 8/8/17, at 1:48 p.m. noted R9 had asked about the new medication. At that time, R9 received an explanation that new medication was for depression and side effects were discussed. During an interview on 8/9/17, at 8:41 a.m., the director of nursing (DON) confirmed there was no documentation that education, including indications for use and possible side effects of the prescribed medication, had been provided to R9 prior to Zoloft administration. The DON stated she expected resident education to occur prior to the administration of the first dose. The DON confirmed Zoloft was administered prior to R9 receiving information about the use and side effects of that medication. A Medication Policy revised 12/15 indicates "education will be provided to the resident regarding safe and effective use of medications." The policy did not indicate when the education would be provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could review and/or revise current policy and procedure regarding informed consent with education to staff provided on current or revised policy and procedures regarding informed consent. The administrator, director of nurses or designee would initiate a program to ensure compliance.	21825		

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	00961	A. BUILDING: _____ B. WING _____	08/10/2017

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21825	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21825		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview, the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 25 residents' families who resided in the facility. Findings include: During interview on 8/9/17, at 1:26 p.m., the administrator confirmed the facility did not have an existing family council. The administrator further confirmed she had not formally attempted to organize a family council in the past year. SUGGESTED METHOD OF CORRECTION: The administrator or designee should ensure thorough attempts are made to develop a family council. The administrator or designee should develop	21915	corrected	9/23/17

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21915	Continued From page 20 monitoring systems to ensure thorough attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915		

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 _____	**08/09/2017**

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

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 09, 2017. At the time of this survey, Good Samaritan Society Winthrop was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. 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, 1995 and 2006. All buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. Previously the 2006 building was surveyed as a separate building and has now been determined to be surveyed as one. 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 36 beds and had a census of 25 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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