

Electronically Delivered November 3, 2023

Administrator Good Samaritan Society - St. James 1000 South Second Street St James, MN 56081

RE: CCN: 245593

Cycle Start Date: August 31, 2023

#### Dear Administrator:

On October 31, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building

HRD 3A 3rd Floor

PO Box 64900, 625 Robert St. N.

St. Paul, MN 55155 Phone: 651-201-4384

Email: holly.zahler@state.mn.us



Electronically delivered

November 3, 2023

Administrator Good Samaritan Society - St James 1000 South Second Street St James, MN 56081

Re: Reinspection Results

Event ID: 532E12

Dear Administrator:

On October 31, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 31, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building

HRD 3A 3rd Floor

PO Box 64900, 625 Robert St. N.

St. Paul, MN 55155 Phone: 651-201-4384

Email: holly.zahler@state.mn.us



Electronically delivered

September 20, 2023

Administrator Good Samaritan Society - St. James 1000 South Second Street St James, MN 56081

RE: CCN: 245593

Cycle Start Date: August 31, 2023

#### Dear Administrator:

On August 31, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by December 1, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

### INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4384

Email: holly.zahler@state.mn.us



Electronically delivered September 20, 2023

Administrator Good Samaritan Society - St. James 1000 South Second Street St James, MN 56081

Re: State Nursing Home Licensing Orders

Event ID: 532E11

#### Dear Administrator:

The above facility was surveyed on August 29, 2023 through August 31, 2023 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html. 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 immediately contact:

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

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

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4384

Email: holly.zahler@state.mn.us

PRINTED: 10/11/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATI IRF		TITI F	(X6) DATE

Electronically Signed 09/29/2023

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 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVE COMPLETED		
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(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.  *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced	A. BUILDI  245593  B. 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This REQUIREMENT is not met as evidenced by:  Based on interview and document review, the facility failed to ensure 5 of 5 new employees reviewed for emergency preparedness (EP) training had received initial training on the EP	PROVIDER OR SUPPLIER  AMARITAN SOCIETY - ST JAMES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SIZE PERFECTED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 4  The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training.  (ii) Provide emergency preparedness policies and procedures as and procedures to all new and existing staff, individuals provide in services under arrangement, and volunteers, consistent with their expected roles.  (iv) Provide emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures as expensioned, and volunteers, consistent with their expected roles, and maintain documentation of the training.  (iv) Demonstrate staff knowledge of emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures are significantly updated, the CAH must conduct training as a least every 2 years.  *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness training at least every 2 years.  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E 037	This deficient practicall 25 residents residents residents residents residents residents residents residents.  Findings include:  Documentation of interpretation of interpretation of interpretation of interpretation and it was not all employees with the provided.  Trained medication and interpretation was training for all employees with the provided of the provide	d annual EP training in 2022. ice had the potential to affect iding in the facility.  Initial EP training was ollowing employees hired in the provided: In aide (TMA)-A, hired 1/10/23 (NA)-B, hired 3/28/23 (RN)-A, hired 4/19/23 13/23 (RN)-A, hired 4/19/23 13/23 (RN)-A in aide for annual EP oyees in 2022 and it was not an employees in 2022 nor for ed in 2023. A policy on EP ployees and annual training		statement of deficiencies. The correction is prepared and/or solely because it is required be provisions of federal and state the purposes of any allegation center is not in substantial conwith federal requirements of puthis response and plan of correctives the center salleg compliance in accordance with 7305 of the State Operations.  1) What corrective actions(s) was accomplished for those reside have been affected by the defipractice.  All five staff members noted required EP training by 9/27. Administrator reviewed the one process for all new employees ensured all current staff have EP training for our facility by 9 the annual EP training for 202 for all staff May 17th, 2023.  2) How you will identify other rehaving the potential to be affers ame deficient practice and was corrective action will be taken.  All residents have the potential affected by this deficient practice in the proper EP training of our facility proper EP training proper EP	executed by the e law. For a that the impliance participation, rection rection Manual.  will be ents found to ficient  eceived the aboarding s and received the aboarding	
				received the annual EP training and the process is in place to new staff receive this training onboarding as well as all staff	ensure all in their	

	PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION    A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245593	B. WING _		08/31/2023
	PROVIDER OR SUPPLIER	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
E 037	Continued From pa	ge 6	EO	required annual training in 2024. We an emergency preparedness section review in QAPI and will review our required trainings each month to ecompliance.  3) What measures will be put in play what systemic changes will you may ensure that the deficient practice direcur.  To ensure systemic changes are sustained, the organization's Emer Management Plan policy has been reviewed and is current. Environment Services Employee, Human Resout Employee, DNS and Administrator all been educated on the policy.  4) How the corrective actions(s) will monitored to ensure deficient praction to recur, i.e., what quality assurant program will be put into practice.  Administrator or designee will audinew hires weekly for the next four to ensure they received their EP trains part of their onboarding and the will continue monthly. Findings will reported to the QAPI committee muntil committee determine substant compliance.  5) The date of compliance is Septe	on to annual nsure  ce or ake to oes not  gency ental urces have  I be tice will nce  t all weeks aining n audit be onthly tial
	EP Testing Require CFR(s): 483.73(d)(2	2)	E 03	29, 2023.	9/29/23

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION DING	· /	E SURVEY IPLETED
		245593	B. WING		08/	C / <b>31/2023</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		JLD BE	(X5) COMPLETION DATE
E 039	§460.84(d)(2), §482 §483.475(d)(2), §482 §485.542(d)(2), §482 *[For ASCs at §416 at §485.542, OPO, §485.727, CMHCs §491.12, and ESRE (2) Testing. The [factor test the emergen must do all of the formulated of the formulation of the emergen community-based of the formulation of the emergen exercise every 2 years, opposite the functional exercise actual event. (ii) Conduct an additional exercise this section is conducted in the formulation of the formulation of the emergen exempt from engage community-based of functional exercise actual event. (ii) Conduct an additional exercise this section is conducted in the formulation of the emergen exercise (ii) Conduct an additional exercise (iii) Conduct an additional exercise (iii) Conduct an additional exercise (iii) Conduct an additional exercise (iiii) Conduct an additional exercise (iiii) Conduct an additional exercise (iiii) Conduct an additional exercise (iiiii) Conduct an additional exercise (iiiiiii) Conduct an additional exercise (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.625(d)(2), §485.727(d)(2), 91.12(d)(2), §494.62(d)(2).  3.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at D Facilities at §494.62]:  cility] must conduct exercises cy plan annually. The [facility] ollowing:  ull-scale exercise that is every 2 years; or unity-based exercise is not a facility-based functional ars; or y] experiences an actual de emergency that requires hergency plan, the [facility] is ing in its next required or individual, facility-based following the onset of the stional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: ale exercise that is or individual, facility-based or		039		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	NG	COM	COMPLETED	
		245593	B. WING		1	31/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	scenario, and a set directed messages designed to challer (iii) Analyze the [fact maintain document exercises, and emergencies, and emergencies at 4 (2) Testing for hos patient's home. The exercises to test the annually. The hospicies at 4 (2) Testing for hospatient's home. The exercises to test the annually. The hospicies (A) When a community based (A) When a community based (B) If the hospice eman-made emergency planengaging in its next community-based facility-based functionset of the emergency planengaging in its next community-based facility-based functionset of the emergency planengaging in its next community-based facility-based functionset of the emergency planengaging in its next community-based facility-based functionset of the emergency planengaging in its next community-based facility-based functionset of the emergency planengaging in its next community-based facility-based functionset of the emergency planengaging in its next community-based facility-based functionset of the emergency planengaging in its next community-based facility-based functionset of the emergency planengaging in its next community-based facility-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its next community-based functionset of the emergency planengaging in its nex	y-relevant emergency to of problem statements, to, or prepared questions nge an emergency plan. cility's] response to and tation of all drills, tabletop ergency events, and revise the cy plan, as needed.  18.113(d):] pices that provide care in the ne hospice must conduct ne emergency plan at least poice must do the following: full-scale exercise that is nevery 2 years; or unity based exercise is not net an individual facility based every 2 years; or experiences a natural or ency that requires activation of not, the hospital is exempt from to required full scale exercise or individual ional exercise following the ency event. ditional exercise every 2 years, ne full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional		39		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	directed messages designed to challent (3) Testing for hospicare directly. The hexercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based function (B) If the hospice examples and a set of problem messages, or prepared that including the angle of the exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (B) A mock disaster (C) A tabletop exercise; or (C) A tab	of problem statements, , or prepared questions age an emergency plan.  sices that provide inpatient hospice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or experiences a natural or ncy that requires activation of n, the hospice is exempt from t required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or reise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.		39		
	Teor PRF is at §44	1.184(d), Hospitals at				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	` '	DATE SURVEY COMPLETED
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	I DF	00/31/2023
10,000	TO VIDER OIL OOF TELET			1000 SOUTH SECOND STREET	<i>-</i>	
GOOD S	AMARITAN SOCIETY	- ST JAMES		ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
			l l	- DELIGITION		
E 039	Continued From pa	ge 10	E 0	)39		
	§482.15(d), CAHs a	at §485.625(d):]				
	(2) Testing. The [PF	RTF, Hospital, CAH] must				
	conduct exercises t	to test the emergency plan				
	•	e [PRTF, Hospital, CAH] must				
	do the following:					
	•	annual full-scale exercise that				
	is community-based	•				
	` '	inity-based exercise is not				
	facility-based functi	t an annual individual,				
	_	onal exercise, or ospital, CAH] experiences an				
	_ ` '	an-made emergency that				
		of the emergency plan, the				
	-	rom engaging in its next				
	required full-scale of	community based or individual,				
	facility-based functi	onal exercise following the				
	onset of the emerge	ency event.				
		[additional] annual exercise or				
	_	le, but is not limited to the				
	following:					
		cale exercise that is				
	<b>,</b>	or individual, a facility-based				
	functional exercise;					
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	disaster drill; or exercise or workshop that is				
		nd includes a group				
		narrated, clinically-relevant				
	,	o, and a set of problem				
	,	d messages, or prepared				
	questions designed	to challenge an emergency				
	plan.					
		[facility's] response to and				
		ation of all drills, tabletop				
	,	ergency events and revise the				
	[facility's] emergend	cy plan, as needed.				
	*[	\ 0.4 ( al\ al\ al\ a				
	*[For PACE at §460	` ' -				
	(2) resung. The PA	CE organization must conduct				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  IG	C (X3) DATE SURVEY		
		245593	B. WING _		1	31/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
E 039	annually. The PACE following:  (i) Participate in an is community-based (A) When a community-based function (B) If the PACE expression man-made emerged the emergency planengaging in its next based or individual exercise following the exercise under parais conducted that must the following:  (ii) Conduct an years opposite the exercise under parais conducted that must the following:  (A) A second full-scommunity-based of functional exercises (B) A mock disasted (C) A tabletop exercise a facilitator and inclusing a narrated, classing and a set directed messages designed to challer (iii) Analyze the PA maintain document exercises, and emergance (B) The ILTC facilities (C) The ILTC facilities (C) The ILTC facilities	e emergency plan at least E organization must do the annual full-scale exercise that d; or unity-based exercise is not an annual individual, ional exercise; or periences an actual natural or ency that requires activation of an, the PACE is exempt from a required full-scale community, facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section may include, but is not limited to cale exercise that is or individual, a facility based correct drill; or recise or workshop that is led by ludes a group discussion, linically-relevant emergency of problem statements, or prepared questions age an emergency plan. ACE's response to and retain of all drills, tabletop ergency events and revise the or plan, as needed.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION  NG	COM	E SURVEY PLETED
		245593	B. WING _			C <b>31/2023</b>
				STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081		
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES (CORRECTIVE ACTION SHOUL)	D BE	(X5) COMPLETION DATE
E 039	including unannour emergency proced ICF/IID] must do th (i) Participate in ar is community-base (A) When a community-based (A) When a community-based functional natural or morequires activation LTC facility is exempled a full-scale individual, facility-be following the onset (ii) Conduct an additional exercise (B) A mock disasted (C) A tabletop exempled a facilitator included narrated, clinically-and a set of problemessages, or prepondallenge an emergical maintain documents and	nced staff drills using the ures. The [LTC facility, e following: a annual full-scale exercise that d; or unity-based exercise is not et an annual individual, ional exercise. Ity] facility experiences an an-made emergency that of the emergency plan, the npt from engaging its next e community-based or ased functional exercise of the emergency event. Iditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based; or er drill; or recise or workshop that is led by a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. IC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to mentation of all drills, tabletop ergency events, and revise the response to the following:  [Recommend of the following is annual full-scale exercise that annual full-scale exercise that		39		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION  NG	) COM	E SURVEY IPLETED
		245593	B. WING			C <b>31/2023</b>
	AME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - ST JAMES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  E 039  Continued From page 13  (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.  (B) If the ICF/IID experiences an actual naturaman-made emergency that requires activation the emergency plan, the ICF/IID is exempt froengaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.  (ii) Conduct an additional annual exercise that may include, but is not limited to the following (A) A second full-scale exercise that is community-based or an individual, facility-base functional exercise; or  (B) A mock disaster drill; or  (C) A tabletop exercise or workshop that is led a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.  (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise ICF/IID's emergency plan, as needed.  *[For HHAs at §484.102]  (d)(2) Testing. The HHA must conduct exercise to test the emergency plan at least annually. The HHA must do the following (i) Participate in a full-scale exercise that is community-based; or  (A) When a community-based exercise is accessible, conduct an annual individual,			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	(A) When a common accessible, conduct facility-based funct (B) If the ICF/IID extra man-made emerged the emergency plate engaging in its nextroommunity-based functional exercise emergency event. (ii) Conduct an additional exercise (B) A mock disaste (C) A tabletop exert a facilitator and inclusing a narrated, consistency, and a set directed messages designed to challer (iii) Analyze the ICF maintain document exercises, and emergency event (CF/IID's emergency event) and a set directed messages designed to challer (iii) Analyze the ICF maintain document exercises, and emergency event (CF/IID's emergency event)	unity-based exercise is not at an annual individual, ional exercise; or. Experiences an actual natural or ency that requires activation of in, the ICF/IID is exempt from the required full-scale or individual, facility-based following the onset of the litional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based; or individual, facility-based; or individual, facility-based; or or critically-relevant emergency to for problem statements, is, or prepared questions and emergency plan.  F/IID's response to and tation of all drills, tabletop ergency events, and revise the cry plan, as needed.  4.102]  HHA must conduct exercises and HHA must do the following: full-scale exercise that is or mmunity-based exercise is not more interesting in the following:	E.O	39		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	TIPLE CONSTRUCTION  ING	` '	ATE SURVEY DMPLETED
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	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES	1	STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
E 039	of the emergency pengaging in its next community-based of functional exercise emergency event.  (ii) Conduct an addition opposite the year the exercise under parais conducted, that limited to the follow (A) A second functional exercise; (B) A mock disa (C) A tabletop of functional exercise; (B) A mock disa (C) A tabletop of functional exercise; (B) A mock disa (C) A tabletop of led by a facilitator and discussion, using a emergency scenarious tatements, directed questions designed plan.  (iii) Analyze the HH documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emergency plan, as to test the emergency plan, as emergency scenarious and iscussion, using a emergency scenarious tatements, directed the emergency scenarious tatements and the emergency tatements	gency that requires activation lan, the HHA is exempt from required full-scale or individual, facility based following the onset of the stional exercise every 2 years, he full-scale or functional agraph (d)(2)(i) of this section it may include, but is not ing: all-scale exercise that is or an individual, facility-based or exercise or workshop that is not includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency.  A's response to and maintain ll drills, tabletop exercises, and and revise the HHA's reeded.		039		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG	COM	E SURVEY PLETED
		245593	B. WING			C 31/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 039	man-made emerge the emergency planengaging in its next following the onset (ii) Analyze the OP documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the following (i) Conduct a paper least annually. A taken the discussion led by a clinically-relevant e of problem statement of problem statement of problem statement and emergency plan. (ii) Analyze the RNI maintain document and emergency plan, as This REQUIREMENT.	periences an actual natural or ncy that requires activation of n, the OPO is exempt from a required testing exercise of the emergency event. O's response to and maintain II tabletop exercises, and and revise the [RNHCI's and plan, as needed.  748]: RNHCI must conduct e emergency plan. The RNHCI ng: rebased, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's		1)What corrective actions(s) wi		
	facility failed to ensign preparedness (EP) full-scale community based exercise, or had actual event, were	exercises, including two by based exercises, or one exercise and a table top tivated their plan as a result of e completed annually to test This had the potential to affect		accomplished for those resident have been affected by the defici practice.  The facility had to activate the e plan by implementing a fire water days due to the loss of communifrom our fire panel on 8/28/23 to the deficient practice. And the a training for 2023 occurred for all 17th, 2023.	mergency ch for two ication correct nnual EP	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245593	B. WING			C <b>31/2023</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP COD 1000 SOUTH SECOND STREET ST JAMES, MN 56081	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE APDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	interim administrate documentation of traction the facility in 2022.	on 8/31/23 at 5:15 p.m., the or stated there had been no raining exercises conducted at A policy on EP exercises had a administrator stated there	E 0	2)How you will identify other rehaving the potential to be affer same deficient practice and w corrective action will be taken.  All residents had the potential affected by this deficient pract emergency plan that was active reviewed and found to have be correctly and efficiently to ensure sident and staff remained sations possible fire.  3)What measures will be put in what systemic changes will you ensure that the deficient pract recur.  To ensure systemic changes a sustained, the organization's Employed and is current. All standard and is current. All standard on this policy 9/27/2  4)How the corrective actions (smonitored to ensure deficient not recur, i.e., what quality assigned program will be put into practice.  Administrator or designee will a year for the next year to ensure proper training is completed be in 2024, or the facility has contimplemented another emerge an actual event. Will review the QAPI to ensure compliance.	to be tice. The vated was een followed ure all afe from a fin place or ou make to tice does not aff were aff were aff were all surance ce.  audit twice sure the by the facility rectly ncy plan in the findings at a findings at	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245593	B. WING				C <b>31/2023</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		10	TREET ADDRESS, CITY, STATE, ZIP CODE  000 SOUTH SECOND STREET  T JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	Continued From page	ge 17	E 0	E 039 29, 2023.			
F 000	INITIAL COMMENT	TS .	F 0	00			
	survey was conduction was all was NOT in compliant 42 CFR 483, Subparterm Care Facilities	laints were reviewed with NO 0095578) 0093255) 0095577) 0091614) 0093820) 0091898)					
	as your allegation of the pottom	f correction (POC) will serve of compliance upon the otance. Because you are our signature is not required if first page of the CMS-2567 ic submission of the POC will tion of compliance.					
<b>F 641</b> SS=D	onsite revisit of you		F 6	41			9/29/23
	§483.20(g) Accurace The assessment more resident's status.	cy of Assessments. ust accurately reflect the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245593	B. WING				24/2022
NAME OF I	PROVIDER OR SUPPLIER	240000	D. W to .	STREET ADDRES	SS CITY STATE ZID CODE	08/	31/2023
NAIVIE OF I	PROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES			ECOND STREET		
				ST JAMES, MI	N 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 641	Continued From pa	age 18	F 6	41			
	This REQUIREME	NT is not met as evidenced					
	by:						
	Based on interview	v and document review, the		,	orrective actions(s) will b		
		ure the Minimum Data Set		-	hed for those residents for		
	,	t accurately reflected the			affected by the deficient		
		needs for 1 of 1 resident (R21)		practice.			
	reviewed for accura	acy of the MDS assessment.		DO1 MDC	datad 2/26/22 baa baan		
	Findings include:				dated 2/26/23 has been o correct the coding for th		
	Findings include.				A1500 completed on 9/2		
	R21's quarterly Mir	nimum Data Set (MDS)		1 AOI (I Cat	A 1000 completed on 5/2	.1725.	
	•	5/25/23, indicated R21 was		2)How you	u will identify other reside	nts	
		3, had intact cognition, no		,	potential to be affected		
		two-person physical assist			cient practice and what		
	with bed mobility, to	ransfers; two-person physical		corrective	action will be taken.		
	assist with dressing	g, toilet use and personal					
	,	wheelchair, diagnoses		l l	its have the potential to b		
	-	sorder, psychotic disorder,		_	y this deficient practice. S		
	· •	n syndrome, musical			vas educated on PASRR	0	
	weakness, difficulty	/ in walking.			S on 9/27/23. And an au		
	D21's admission M	DC datad 2/26/22 Jackad			r all current residents will		
		DS dated 2/26/23, lacked a serious mental illness and/or		completed	by Social Services by 9/	20/23.	
		y or a related condition.		3)\M/hat m/	easures will be put in pla	ce or	
	intenectual disabilit	y of a related condition.		,	emic changes will you ma		
	On 8/30/23 at 1·17	p.m., registered nurse (RN)-B			at the deficient practice d		
		r of nursing (DON), stated		recur.	it the denoishit practice d		
		OS was completed by offsite					
		she recently been hired at the		The organ	ization⊟s policy Pre-Adn	nission	
	facility as the MDS	nurse, and another unknown		Screening	and Resident Review		
	nurse had complete	ed the admission MDS prior to		(PASARR)	) □ Rehab/Skilled has be	en	
		e facility. The interim DON			and is current. Social Ser		
		Imission MDS assessment		•	ete coding A1500 on all f		
		rately coded and lacked			MDS assessments. All		
	documentation of s	serious mental illness.			s going forward will be	_	
	O= 0//00/00 1 0 00	\			coded based on outcom		
	On 8//30/23 at 3:30	•		tne PASRF	R notice at time of admis	sion.	
		ed R21's admission MDS had		1) Llovy the	corrective estimate(a) will	l bo	
	Deen coded maccu	rately, and should had		<del>4</del> )⊓ow the	corrective actions(s) will	DE	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245593	B. WING _		ı	C <b>31/2023</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP C 1000 SOUTH SECOND STREET ST JAMES, MN 56081	<u>'</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 641	resident review to he The interim administrate and a new was not completed. The facility MDS 3. (Resident Assessment facility MDS 3. (Resident Assessment referends and acknowledged. 12. The RN MDS conditions or warnings acknowledged. 12. The RN MDS costing and date the National RN MDS is seen and RN MDS is seen an	eadmission screening and have a serious mental illness. strator stated the facility had w MDS nurse and R21's MDS by on site facility staff.  O (Minimum Data Set) RAI nent Instrument) policy dated revation period each team of the EMR to determine if there entation to support coding for ation will need to review mentation requirements and ents to determine the MDS supportive documentation does or to the assessment reference on the responsible for coding a supportive documentation DS. If while reviewing the team member finds conflicting clarifying note will be written in art of the supportive e. Cation must be completed after a coded and signed their or warnings must be reviewed on of the entire MDS. Any must be reviewed and coordinator/ RN Designee will MDS signifying it as complete e cannot be prior to the noce date.	F 64	monitored to ensure deficie not recur, i.e., what quality a program will be put into pra  Director of nursing or desig all admission MDS complet 4 weeks for accuracy then admission a month x 3 mor accurate coding of A1500 of against the PASRR report, will be brought to the month committee for input on the mincrease, decrease or disconsisted of the compliance is 29, 2023.	nee will review ed for the next will review 1 the MDS Audit results aly QAPI need to ontinue audits.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245593	B. WING _			31/ <b>2023</b>
	PROVIDER OR SUPPLIER	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 641	Summary. b. The RN MDS coordelectronically sign V signifying completion c. Care Plan Review each discipline after completed. The care MDS completion, w and 14-day if the initic completed yet. d. The care plan consign V0200C1 and completion of the care plan consign V0200C1 and completion of the care and service appropriate setting. Before Admission: 5. The level II PASA by the agency designs creening will determine the care and service appropriate setting.	ordinator/ RN Designee will /0200B1 and date V0200B2 on of the RAI process. w - PN must be completed by r each MDS is signed as e plan is reviewed with each ith the exception of the 5-day tial care plan has not been ordinator will electronically date V0200C2 signifying are plan process.	F 64			
<b>F 644</b> SS=D	Specialized services Coordination of PAS CFR(s): 483.20(e)(2) §483.20(e) Coordin A facility must coord	SARR and Assessments  1)(2)	F 64	14		9/29/23

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	COM	E SURVEY PLETED
		245593	B. WING			C 31/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUNDERSE ACT	JLD BE	(X5) COMPLETION DATE
F 644	of this part to the mayoid duplicative to includes:  §483.20(e)(1)Incompression the PASARR PASARR evaluation assessment, care care.  §483.20(e)(2) Referral residents with maserious mental discompression to the facility for a significant chang. This REQUIREME by:  Based on observative with effective the facility for recommendations determination and into a resident's ascomprehensive careviewed.  Findings Include:  R21's quarterly Minassessment dated admitted on 2/20/2 behaviors, required with bed mobility, the assist with dressing hygiene; utilized a sincluded: bipolar dipost traumatic streen.	n under Medicaid in subpart C naximum extent practicable to esting and effort. Coordination porating the recommendations level II determination and the n report into a resident's clanning, and transitions of erring all level II residents and ewly evident or possible order, intellectual disability, or a probability of the resident review upon the instatus assessment. The is not met as evidenced to incorporate the from the PASARR level II the PASARR evaluation report sessment, care planning, and the for 1 of 3 residents (R21) simum Data Set (MDS) 5/25/23, indicated R21 was 3, had intact cognition, no a two-person physical assist ransfers; two-person physical assist ransfers; two-person physical growth to the proposition of two-person physical disorder, so disorder (PTSD), chronic usical weakness, difficulty in	F 6	1)What corrective actions(s) wil accomplished for those residents have been affected by the deficie practice.  R21 has been offered to go out f health services, had also contact R21□s guardian to setup an app but resident has declined to leav facility for an appointment. Also psychiatrist has been contacted contract with the facility to see th resident/s onsite in person. Facil also contacted Meditelecare to c with our facility so R21, along wit residents, would also have the o meet via telehealth.  2)How you will identify other residenting the potential to be affected same deficient practice and what	found to ent  for mental ted to the atto the all to the all ption to the atto the atto the all ption to the atto the all ption to the atto the all ption to the atto	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	l \ '	(X3) DATE SURVEY COMPLETED	
		245593	B. WING			31/ <b>2023</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>	31/2023
				1000 SOUTH SECOND STREET		
GOOD S	AMARITAN SOCIETY	- ST JAMES		ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 644	Continued From pa	age 22	F 6	644		
	•			corrective action will be take	n.	
	R21's admission M	DS dated 2/26/23, indicated				
		ntly considered by the state		All residents have the potent	ial to be	
	level II PASRR pro	cess to have serious mental		affected by this deficient prac	ctice. 9/28	
		ectual disability or a related		review of PASRR was compl		
	condition.			other residents are at risk. F	•	
		l Dua a duais ai an Cana anin n		contacted mental health prov		
	·	l Preadmission Screening with mental illness initial		(Sanford Psychology and Me start providing mental health	,	
		2/15/23, was completed for		all residents in need.	Services for	
		R21 continued psychiatric		an residents in need.		
		ement and should receive		3)What measures will be put	t in place or	
	_	ces while at the nursing facility		what systemic changes will y	•	
	,	entation revealed resident had		ensure that the deficient prac	ctice does not	
	refusal of cares and	d delusions.		recur.		
	R21's care plan da	ted 8/31/23, indicated R21		To ensure systemic changes	are	
	•	acological medications r/t		sustained, the organization□		
	(related to) delusio	nal disorder and PTSD and		Behavioral Health Services F	Rehab/Skilled	
		led: consult with pharmacy,		and Pre-Admission Screening	•	
	•	er, etc. to consider dosage		Resident Review (PASARR)		
		nically appropriate, discuss with		Rehab/Skilled has been review		
	•	er, family regarding ongoing		current. Education provided	•	
	need for use of me	ut risks, benefits and the side		staff responsible for resident and social services.	assessments	
		symptoms of medication,		and Social Scretces.		
		ndition based on clinical		4)How the corrective actions	(s) will be	
		or clinical standards of		monitored to ensure deficien	` '	
	practice r/t use of c	lanzapine.		not recur, i.e., what quality as	ssurance	
				program will be put into prac	tice.	
		cord indicated no psychiatry				
	• • ·	ntal health treatments, support		The Director of Nursing or de	•	
	,	ualized nursing interventions		audit all admission PASRRs		
	related to PTSD.			MDS assessments weekly for four weeks then monthly for		
	R21's nhysician vis	it notes were reviewed and the		to ensure the PASRR recom		
		specifically identify, address		have been incorporated into		
		1's PTSD, effectiveness of any		resident □s care plan. Finding		
		oing plan for treatment.		brought to the QAPI committ	_	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245593	B. WING _			C <b>31/2023</b>
	NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - ST JAMES  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 644  Continued From page 23  On 8/30/23 at 11:43 a.m., R21 was observed in bed, the doors to room closed, and the lights of R21 was wearing a hospital gown, appearance was of being sad, with flat affect. R21 stated sh stayed in her room usually, and had not been offered any mental health services. R21 said sh did not have anyone in the facility to talk with on consistent basis, and was not aware she had a medical provider or doctor who took care of her medical concerns. R21 stated she infrequently attended activities due to not liking to leave her room due to pain and her low immune system. R21 stated she was unaware of any intervention to address her mental health.  On 8/30/23 at 1:17 p.m.,social services (SS)-A stated the MDS assessments were completed by staff off site and was not aware the PASARR level II had not identified R21 to have a serious men illness. SS-A stated the PASARR level II was not aware			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 644	On 8/30/23 at 11:4 bed, the doors to re R21 was wearing a was of being sad, was of being sad, was of being sad, was did not have anyon consistent basis, a medical provider of medical concerns. attended activities room due to pain a R21 stated she was to address her medical concerns. attended activities room due to pain a R21 stated she was to address her medical concerns. Attended activities room due to pain a R21 stated she was to address her medical concerns. Attended activities room due to pain a R21 stated she was to address her medical concerns. Attended activities room due to pain a R21 stated she was the facility at 1:17 stated the MDS as staff off site and was staff off si	3 a.m., R21 was observed in com closed, and the lights off. In hospital gown, appearance with flat affect. R21 stated she usually, and had not been health services. R21 said she in the facility to talk with on a nd was not aware she had a redoctor who took care of her R21 stated she infrequently due to not liking to leave her nd her low immune system. Is unaware of any interventions intal health.  p.m., social services (SS)-A sessments were completed by as not aware the PASARR level I R21 to have a serious mental of the PASARR level II was not exercise sessments.  a.m., during a telephone ardian stated R21 had a mental and expected R21's care chiatry. R21's guardian stated if R21 had seen psychiatry		determine compliance.  5)The date of compliance is Sept 29, 2023.	tember	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 644	director of nursing (unaware R21 had a SS-A and the interir II was not utilized du The interim DON ag should have been provided the second and been provided to recommendations of the facility Pre-Adm Resident Review (Proceeding 12/21/22, indicated:  Purpose To determine admission and a service appropriate setting.  Before Admission:  5. The level II PASA by the agency designs acreening will determine the location weather specialized services.	p.m., SS-A and the interim DON) stated they were PASARR level II completed. DON verified PASARR level uring the MDS assessment. Dreed mental health services provided for oversight of R21's poses. The interim DON and 1, had no other notes or insure mental health services timely and with the of the PASARR level II.  Inission Screening and PASARR) policy dated  Sign criteria for residents with principle of the passion of the	F 64				
<b>F</b> 726 SS=F	Competent Nursing CFR(s): 483.35(a)(3) §483.35 Nursing Se	3)(4)(c)	F 72	26		9/29/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1000 SOUTH SECOND STREET ST JAMES, MN 56081	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 726	the appropriate corprovide nursing an resident safety and practicable physical well-being of each resident assessment and considering the diagnoses of the faccordance with that §483.70(e).  §483.35(a)(3) The licensed nurses had and skill sets neces needs, as identified assessments, and §483.35(a)(4) Provide to resident's needs for each set of the facility must ento demonstrate contechniques necessing implementing resident's needs for each set of the facility must ento demonstrate contechniques necessing in the facility facility must ento demonstrate contechniques necessing in the facility faci	ave sufficient nursing staff with impetencies and skills sets to direlated services to assure attain or maintain the highest all, mental, and psychosocial resident, as determined by ents and individual plans of care enumber, acuity and acility's resident population in efacility assessment required facility must ensure that exercise the specific competencies assary to care for residents' different described in the plan of care.  Inding care includes but is not good, evaluating, planning and lent care plans and responding and lent care plans and responding any to care for residents' different that nurse aides are able meterney in skills and any to care for residents' different described in the plan of care.  Note that nurse aides are able meterney in skills and any to care for residents' different described in the plan of care.  Note that nurse aides are able meterney in skills and any to care for residents' different described in the plan of care.  Note that nurse aides are able meterney in skills and any to care for residents' different described in the plan of care.  Note that nurse aides are able meterney in skills and any to care for residents' different described in the plan of care.  Note that nurse aides are able meterney in skills and any to care for residents' different described in the plan of care.  Note that nurse aides are able meterney in skills and ary to care for residents' different described in the plan of care.	F 72	1)What corrective actions(s accomplished for those resid have been affected by the depractice.  The facility currently is not us agency staff. For all potential agency staff, the facility has	dents found to eficient tilizing any I future		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	· /	(X3) DATE SURVEY COMPLETED	
		245593	B. WING			C <b>31/2023</b>	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
00000	**** DIT **! O O O I E T \	OT 14140		1000 SOUTH SECOND STREET			
GOOD S	AMARITAN SOCIETY	- ST JAMES		ST JAMES, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 726	Continued From pa	age 26	F 7	'26			
F 726	On 8/29/23 at 2:36 (NA)-A stated the facility mechanic on 8/29/23 at 2:36 (NA)-A stated the facility staff came one hou and received an hotor residents on the was not enough time everything. NA-A stated to the facility end for the end for the end for the end familiar with the factor of the end familiar with the factor of the end facility staff for the end familiar with the factor of the end familiar with the factor of the end facility staff for the end familiar with the factor of the end facility staff for the end facility staff and had monthed the end facility staff and had monthed the end facility mechanic observed agency in the facility mechanic observed agency is shower chair lifts of the end for the end for the end facility mechanic observed agency in the facility mechanic observed agency is shower chair lifts of the end for the end for the end facility mechanic observed agency is shower chair lifts of the end for the end f	p.m., agency nursing assistant acility used a lot of agency ing NA's. NA-A stated agency in prior to their scheduled shift our of orientation before caring air own. NA-A stated one hour ne to show and explain tated when she arrived one at shift, she was provided included resident's names at NA-A stated the facility did of the facility, resident specific ar status of the resident's, or equipment, and was unable to nic medical record (EMR) and stated the staff who other agency staff who was not cility and stated, "I have just A-A stated the facility did not check sheet. NA-A stated she now residents transferred and on status on the resident each resident room had a wall with information written on on status. NA-A stated she e board as well to determine p.m., NA-B stated she was d worked at the facility for six agency staff did not receive ning and were not familiar with ital lifts, and stated she had lA's not sure how to use the rethe slings for the mechanical		training program with a compelist to ensure that agency staff competency requirements for care before starting to work.  2) How you will identify other rehaving the potential to be affesame deficient practice and we corrective action will be taken.  All the residents at the facility potential to be affected by the practice. For any agency staff the DNS/designee will ensure program with competency chebeen completed to ensure the staff meet the training require.  3) What measures will be put what systemic changes will you ensure that the deficient practice.  To ensure systemic changes sustained, the organization of Contingent Lab Responsibilities as well as the Contingent Staff Orientation of been reviewed and is current. leadership have been trained to ensure all staff get trained a competent to care for resident to the policy and procedure.  4) How the corrective actions (4)	esidents esidents esidents eted by the hat have the deficient contracted the training eck list has agency ments. In place or ou make to tice does not ere checklist has The facility on the policy and are ts according es) will be		
	lifts, and would inte assist agency staff.	ervene when observed to		monitored to ensure deficient not recur, i.e., what quality as program will be put into practi	surance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	(X3) DATE SURVEY COMPLETED	
		245593	B. WING			C <b>31/2023</b>	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 1000 SOUTH SECOND STREET ST JAMES, MN 56081	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 726	nursing (DON) state responsible for or interim DON state before the start of facility tour and shour. The interim orientation was exported another agency DON stated skille hours prior to their interim DON state be trained on facility used an or staff and new facility used an or staff and resident specific in agency staff were access or their EN work.  On 8/31/23 10:59 coordinator, state and was responsing stated agency NA for one hour prior scheduling coordinator confined the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the residuction of a checklist for a stated the oriental cheat sheet for register the register the register than the register t	9 a.m., the interim director of ated the staff scheduler was ientation for agency NA's. The ed agency NA's came one hour their shift, and were given a nadowed another NA during that DON stated the one-hour expected from facility staff and cy staff member. The interimed nursing staff came in two ir shift for orientation. The ed agency staff were expected to lity specific information that ent, and would use the EMR to ambulation status and resident on. The interim DON stated the ientation checklist for agency	F 7	Facility will conduct rando for any new agency staff of ensure they were trained. reported to the QAPI compliance.  5) The date of compliance 29, 2023.	Findings will be mittee monthly nines substantial		

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		245593	B. WING _			C 31/2023	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE	
F 726	interview the interir had not provided a the orientation cheexpected. The interexpected. The interexpectation that ag NA duties, had a consist of agency staff. The sometimes agency were assigned to the care. The interim Expreferred, but some nurses and NA's as On 8/31/23 at 11:29 administrator state to utilize the oriental interim administrator this time, and state re-implement the oriental interimental practice did not incertain the facility assessing contacted workers or provide certain some completed, exand whirlpool spare completed, exand whirlpool spare completed, exand whirlpool spare completed, exand whirlpool spare or provide certain some completed certain some certain	O a.m., during a follow up in DON confirmed the facility gency NA's or nursing staff cklist for agency staff as rim DON stated it was her gency NA's were competent in ertain skill set and were familiar ment. The interim DON ity utilized a significant number e interim DON stated is staff were the only staff who he facility to provide resident DON stated that was not etimes they were the only vailable.  9 a.m., the interim diagency staff were expected ation check list. However, the or confirmed the facility current lude the agency check list at and going forward would wrientation check list.  ment dated 8/22/23, indicated will not use facility equipment services unless competencies (example) using lift equipment Checklist will be utilized per ment with staffing agency-Fadicated one hour of orientation		26			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		` '	(X3) DATE SURVEY COMPLETED			
		245593	B. WING			C 08/31/2023
NAME OF F	PROVIDER OR SUPPLIER		l	STREET ADDRESS, CITY, STATE, ZIP C	<b>.</b>	00/31/2023
GOOD S	AMARITAN SOCIETY	- ST JAMES		1000 SOUTH SECOND STREET ST JAMES, MN 56081		
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F 726	Continued From pa	ge 29	F 7	726		
	OSHA resident right qualifies workers for legal liabilities of chasic disaster policinfection control, the Society with oriental Document title GSS other contingent states 9/21, indicated: -Please return the a within 48 hours of years assignment with Go	ts, a written test which or the duties they will perform, arting, vulnerable adult laws, ies, safety in resident care, e agency will provide the tion materials upon request.  S Contingent Labor CNA & aff orientation check list dated attached orientation check list dour traveler starting their bod Samaritan Society. It is document is complete, as this				
	is required compliant Purpose: the intent an accelerated expended Audience: Good Sacare contingent laboratest	•				
	unsupervised only a completed. Agency training (coorganization, identification, identification) basic safe corporate compliant neglect and exploitate reporting, HIPPA, horesident rights, infection and responsion preventing unnecessive and responsion review how to log of shift routines, assigned the resident care plans breaks/phone policicials.	after competency validation is mpleted prior to start): intro to fication, incident/accident ety and OSHA standards, ce, documentation, abuse, ation elder Justice Act azard communication, ction control, BBP, TB, nent, advanced directives, ssary hospitalization. bilities: n using Quick Badge nments, responsibility and				
	reporting to nurse a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION  IG	COM	E SURVEY  IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 727	release snap if apprincontinence productions supplies nursing assistant description of the production	In demonstration of quick licable to location call light, cts  ocumentation loffing iene and hand washing  building equipment tion checklist in unit with preceptor (k, Full Time DON 1)-(3)  ared nurse ept when waived under of this section, the facility tes of a registered nurse for at a hours a day, 7 days a week.  ept when waived under of this section, the facility egistered nurse to serve as the	F 72			9/29/23
	as a charge nurse average daily occur This REQUIREMENT by: The facility's request and and approved following the survey re-issued at PAST NO plan of correction effect until such the such that the such thas the such that the such that the such that the such that the su	director of nursing may serve only when the facility has an pancy of 60 or fewer residents. NT is not met as evidenced est for a waiver was accepted by the State Agency following y exited 2/27/23. The tag was NON-COMPLIANCE; therefore on is required. This will remain time as the registered nurse be filled and the facility		POC is not required.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	(X3) DATE COME	E SURVEY PLETED
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F 727	achieves compliand F727: CFR 483.35 consecutive hours a Findings include: Review of nursing s identified no registe scheduled on 8/9/23 8/1/23. On 8/31/23 at 11:26 administrator stated waiver for RN cover currently working or interim administrator an additional RN to shifts and was currently stagger the RN care another RN and will shifts to provide betweekends. During the administrator stated more RN's and were review of the upcontact of the stagger in training and review of the upcontact of the stagger in training and review of the upcontact of the stagger in training and review of the upcontact of the stagger in training and review of the upcontact of the upc	chedule in the last 30 days red nurse (RN) had been 3, 8/8/23, 8/7/23, 8/3/23,  a.m., the interim I the facility had obtained a rage and the facility was a filling the positions. The restated the facility had hired fill the eight hour weekend ently working on a plan to be coordinators hours with have RN's rotate weekend ter RN coverage on the he interview the interim I the facility had recently hired the interview the interim I the facility had recently hired the interview of orientation.  The process of orientation and identified RN's orientation and identified the attempting RN coverage to	F 72	27		
F 740 SS=D	CFR(s): 483.40 §483.40 Behavioral Each resident must provide the necessal services to attain or		F 74	40		9/29/23

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 740	Continued From pa	ige 32	F 7	40			
	assessment and plencompasses a residential well-being, well-being, well-being, well-being and substance use This REQUIREMENTAL by:  Based on interview review, the facility for the second substance were substance.	NT is not met as evidenced  v, observation, and document ailed to offer mental health		1)What corrective actions(s) vaccomplished for those residents accomplished by the definition of the	nts found to		
	well-being of 1 of 1	e and/or support the mental resident (R21) diagnosed with ss disorder (PTSD).		have been affected by the deficient			
	assessment dated admitted on 2/20/23 behaviors, required with bed mobility, trassist with dressing hygiene; utilized a vincluded: bipolar dis	nimum Data Set (MDS) 5/25/23, indicated R21 was 3, had intact cognition, no I two-person physical assist ransfers; two-person physical g, toilet use and personal wheelchair, diagnoses sorder, psychotic disorder, n syndrome, musical y in walking.		R21 has been offered to go ou health services but she decline facility had also contacted R21 guardian to setup an appointm resident declined again. Social met with resident individually 9 and had her care conference was guardian 9/13 to discuss her care remind her of extra services as And a psychiatrist has been contract with the facility to see resident/s onsite.  2)How you will identify other re	ed. So,  sent but Worker 7 and 9/25 with the are and ailable. Intacted to the		
	used psychopharm (related to) delusion interventions included health care provided reduction when clinically also resident/family about effects and/or toxic monitor resident contact to the contact and the contact a	ted 8/31/23, indicated R21 acological medications r/t nal disorder and PTSD and led: consult with pharmacy, er, etc. to consider dosage lically appropriate, discuss with er, family regarding ongoing dication, educate ut risks, benefits and the side symptoms of medication, endition based on clinical or clinical standards of		having the potential to be affect same deficient practice and what corrective action will be taken.  All residents have the potential affected by this deficient practice review of PASARR was completed to the residents are at risk. All of the residents diagnoses were residents are social worker on 9/28 and with a mental health diagnosis rescreened with the PASARR I	ted by the nat  I to be ce. 9/28 eted and no current viewed by all residents will be		

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F 740	Continued From p	age 33	F 7	40			
	medication).  Trauma Assessme	olanzapine (antipyschoitc ent dated 2/27/23, indicated		(Sanford Pastart provid	ted mental health provided sychology and Mediteled ling mental health services in need on site.	care) to	
	R21 had indicated	no experienced trauma.			easures will be put in pla		
	persons with ment dated 2/15/23, ind psychiatric medica	sion Screening (PAS) for tal illness initial assessment icated R21 continued ation management and should alth services while at the		ensure that recur.  To ensure s	mic changes will you ma t the deficient practice d systemic changes are	oes not	
	R21's guardian was to meet with patient and for outpatient work will coordinate coordinate and plant and plant work will and plant coordinate and plant coor	notes dated 9/13/22, indicated as in agreement with psychiatry at for medication assessment psychiatry follow up, social te with the health unit ace an order for follow up cheduled prior to patients		Behavioral has been re Director of Social Wor this policy. health prov Mediteleca	the organization s policed Health Services Rehability and is current. Increasing, Administrator at the facility has contacted maken (Sanford Psychologies) to start providing medices for all residents in residents in residents.	Skilled and d on nental ogy and ental	
	indicated consult a scheduled include general consult, in assessment and d disorder, schedule	and follow up appointment to be d psychiatry and psychology dication: medication clinical question: delusional ers have made the appointment ellow up at Psychiatry Clinic,		monitored to not recur, in program with admission lassessment	corrective actions(s) will to ensure deficient pract e., what quality assurantill be put into practice.  or designee will audit all PASRRs and initial MDS onts weekly for the next for the monthly. Findings will be	ice will ice Sour	
	Progress note on indicated a care conguardian, staff, an had no concerns,	lers dated 8/31/23, indicated nagement of mental health.  3/8/2023, social services (SS)-A onference included R21's d R21 did not wish to come and nursing reported R21 was without issues, SS-A went over		reported to until comm compliance	the QAPI committee monittee monittee determine substant	onthly tial	

T' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C  1000 SOUTH SECOND STREET  ST JAMES, MN 56081	<u>'</u>	70/31/2023	
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F 740	Continued From pa	ige 34	F 7	740			
	about her delusions is hard to know white was informed that it guardians will look psychiatric doctor.  Review of R21's reappointments, menservices, or individual related to PTSD was related to PTSD was visit notes did not sand/or mention R2 treatments, or ongoton 8/30/23 at 11:43 bed, the doors to reappointments, or ongoton 8/30/23 at 11:43 bed, the doors to reappoint was of being sad,	it notes were reviewed, the specifically identify, address 1's PTSD, effectiveness of any bing plan for treatment.  3 a.m., R21 was observed in boom closed, and the lights off. hospital gown, appearance with flat affect. R21 stated she usually, and had not been health services. R21 said she in the facility to talk with on a nd was not aware she had a doctor who took care of her R21 stated she infrequently due to not liking to leave her nd her low immune system. Is unaware of any interventions at all health.  2 a.m., trained medication aide 1 did not get out of bed or the R21 was embarrassed ma.  3 p.m., SS-A stated R21 had a					
		t completed on admission and					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	` '	TE SURVEY MPLETED
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F 740	trauma. SS-A verification PTSD however this R21, due to her star previous trauma. Stayed in her room feared germs, does she does not like to further indicated R2 an appointed guard. On 8/31/23 at 8:07 interview R21's guard. On 8/31/23 at 10:12 (NP)-D confirmed R2 was not aware if R2 On 8/31/23 at 10:12 (NP)-D confirmed R2 since R21 had admicurrently there was the facility. NP-D corounds and address determined necess stated she would exhospital discharge of On 8/31/23 at 12:44 bed, the doors to the off. R21 was wearing watching television history of trauma.  On 8/31/23 at 2:42 stated R21 had a seappointment on 3/1 was canceled on duand the interim DOI and the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the interim DOI are room for the stayed R21 had a seappointment on 3/1 was canceled on duand the seappointment on 3/1 was canceled on duand the seappointment on 3/1 was cance	at time she had no previous ed R21's diagnosis included had not been discussed with ting on admission she had no S-A stated R21 frequently and in bed because R21 anot like crowds, and stated around be people. SS-A 21 had an opioid addiction, and		740		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	DING	` '	E SURVEY IPLETED
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F 740	responsible to reschappointment. The confirmed R21 had services at this time discharge orders for agreed mental heal provided for oversign diagnoses. The intronfirmed R21, had documentation to enhal been provided.  The facility Trauma 10/26/22, indicated Purpose: To provide trauma intraumatizing reside Policy: staff will ensure that trauma received curinformed care acconstandards of practice resident's experient to eliminate or mitigate-traumatization. each employee will residents with mental as well as residents their post-traumatice. Procedure: 2. the drama assesses services while interresident/represental 3. while conducting the residents experience the behavior 4. document how the confirment of the co	S-A stated the facility was hedule R21's psychiatric interim DON and SS-A no other behavioral health and expected the hospital llowed. The interim DON th services should have been ght of R21's mental health erim DON and SS-A no other notes or insure mental health services timely.  Informed Care policy dated informed care and avoid rents.  It residents would experience liturally competent trauma rdance with professional ce and accounting for ces and preferences in order pate triggers that may cause have training and caring for call and psychosocial disorders with the history of trauma in extress disorder.  Sments completed by social viewing the tive the focus on understanding ience rather than trying to		740		

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F 740	Continued From pa	ge 37	F 7	40				
F 756	re traumatization; for well-being deficit for trauma. 6. when indicated reprofessional. Drug Regimen Rev	re plan interventions to avoid ocus number 2 psychosocial r actual or potential to relieve efer to a clinical/mental health iew, Report Irregular, Act On	F 7	'56			9/29/23	
SS=E	must be reviewed a licensed pharmacis	egimen Review. drug regimen of each resident it least once a month by a it.						
	irregularities to the facility's medical dirand these reports in (i) Irregularities incording that meets the (d) of this section for (ii) Any irregularities during this review in separate, written reattending physician director and director and director minimum, the resident and the irregularity (iii) The attending physician for irregularity has been action has been taken the process of the control of the co	charmacist must report any attending physician and the ector and director of nursing, nust be acted upon. It lude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug. In an unnecessary drug, and the facility's medical rof nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. In the record that the identified in reviewed and what, if any, the tento address it. If there is to be medication, the attending ocument his or her rationale in cal record.						

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F 756	Continued From pa	age 38	F 7	56			
	maintain policies and drug regimen reviewed to, time franche the process and standard when he or she iderequires urgent act. This REQUIREME by:  Based on interview facility failed to ensemble to ensemble for 4 of 5 residents reviewed for unnecessing include:  R13's quarterly MD indicated R13 was one-person physical transfers, dressing hygiene, utilized a second control of the process of the pr	facility must develop and and procedures for the monthly with that include, but are not mes for the different steps in eps the pharmacist must take entifies an irregularity that ion to protect the resident. NT is not met as evidenced and document review, the sure consulting pharmacist were addressed or acted upon (R10, R13, R15, and R18) ressary medications.  S assessment dated 7/21/23, cognitively intact, required, all assistance with bed mobility, toilet use, and personal wheelchair, diagnoses included epression, and medications		1)What corrective actions(s) will accomplished for those residents have been affected by the deficie practice.  R10, R13, R15 and R18 recommendations have been adper consulting pharmacist recommendations.  2)How you will identify other residuating the potential to be affected same deficient practice and what corrective action will be taken.	dressed dents do by the		
	injections, antianxion and opioid.  R13's physician order multiple scheduled	d pain medication, insulin ety, antidepressant, diuretic, ders dated 8/31/23, included medications which included diabetic medications, and		All residents had the potential to affected deficient practice. All respharmacy recommendations for month of September 2023 have reviewed by 9/28/23.	sidents□ the		
	R13's care plan day on medications with warnings of advers to): pain managem	tion.  ted 8/31/23, indicated R13 was h FDA boxed warning or e consequences r/t (related ent, diuretic use,		3)What measures will be put in power what systemic changes will you rensure that the deficient practice recur.  To ensure systemic changes are	make to does not		
	-	rapy and HTN (hypertension) tions included: consult with		sustained, the organization⊟s po Medication: Drug Regimen Revie	•		

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F 756	Continued From pa	age 39	F 7	56			
		are provider, etc. to consider with clinically appropriate.		been reviewed and is current consulting pharmacist will see report at the end of every more	end GDR		
		nsultant pharmacist progress adjusted the following repeat		director of nursing and designment of staff gives the original copy to	•		
	requests to provide	<b>.</b>		review on the next schedule			
	8/29/23, No response	onse to previous yet, will resend again.		Then once NP reviews, a co the NP is placed in a binder			
		g clarification of orders.		signed copy is uploaded to E			
	•	g last month's note to new		so everyone can see this. Ag			
	DON. 4/14/23, no respo	nse to duplicate		added to the QAPI meeting these. Education has been of			
	antidepressant not	e from last month yet.		this process for IP Nurse Ma Director of Nursing.	nager and		
		S assessment dated 7/21/23,		4)	(a):!!! la a		
		a severe cognitive impairment, on physical assistance with		4)How the corrective actions monitored to ensure deficient	` '		
	bed mobility, transf	ers, dressing, toilet use, and		not recur, i.e., what quality as	ssurance		
		utilized a wheelchair, I non-traumatic brain		program will be put into prac	tice.		
	•	Izheimer's dementia,		Director of Nursing or design	nee will audit		
	-	sychotic disorder, and		the GDR and ensure the NP			
	medications indicate antipsychotic, antid	lepressant medications.		given the report and has rev recommendations timely, mo			
	D15's physician are	doro dotod 9/21/22 included		months. Findings will be repo	orted to QAPI		
	. ,	ders dated 8/31/23, included medications which included		to ensure compliance.			
	an antidepressant,	pain medications, and an		5)The date of compliance is	September		
	antipsychotic medi	cation.		29, 2023.			
	used antidepressar and interventions in pharmacy, healthca dosage reduction v psychopharmacolo disorder e/b (evide	• •					
	. ,	cation and interventions ith health care provider, re					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING	\ \ \ \ \	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP COD 1000 SOUTH SECOND STREET ST JAMES, MN 56081	<u> </u>	
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F 756	condition based on clinical standards of R15's review of cornotes in the EMR in requests to provide6/20/23, No response her resending last5/18/23, resending4/14/23, no response her resending last5/18/23, resending note. R10's facesheet pridiagnoses of deprediagnoses of deprediagnoses of deprediagnoses of daily liver R10's physician or activities of daily liver R10's physician or scheduled medication and to a constitute of daily liver R10's care plan with indicated R10 was medication and to a provider and family medication; to constitute of consultation in the electronic medical approvide when clinically approvides of consultation in the electronic medical standards and several standa	medication, monitor resident clinical practice guidelines f use r/t of anti-psychotic.  multant pharmacist progress adicated the following repeat r:  muse to GDR yet, there has ponty's, will send last months to month's note to new DON.  If GDR muse to last month's GDR yet.  If principle principle graph (as needed) lorazepam anted on 8/31/23, included resion, dementia, and anxiety.  Immum Data Set (MDS)  8/4/23, indicated R10 had a cognition and required repeated of one staff for most required repeated for most required repeated and a medication.  In revised date of 7/7/22, on an antidepressant discuss with health care, ongoing need for use of sult with pharmacy and/or repeated reduction.		56		

NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - ST JAMES  SITERET ADDRESS, CITY, STATE ZIP CODE 1000 SOUTH SECOND STREET ST JAMES, MN 59081  SUMMAN SOUTH SECOND STREET ST JAMES, MN 59081  F 756  Continued From page 41  -5/18/23: Recommendation: antidepressant gradual dose reduction (GDR) -6/20/23: GDR not responded to yet; will send to new DON.  -7/25/23: Fluoretine (antidepressant) GDR resent8/29/23: No response to previous antidepressant GDR yet -will resend.  R18's quanterly MDS assessment dated 7/6/23, indicated R18 had moderately impaired cognition and required limited assistance of staff when moving about the facility in a wheelchair.  R18's care plan with revised date of 7/25/23, indicated R18 was on antipsychotic and antidepressant medications including an antipsychotic and antidepressant medications and to consult with pharmacy and health care provide for consider dosage reduction when clinically appropriate.  Review of consultant pharmacist progress notes in the EMR, indicated the following repeat requests to provider6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend6/20/23: No response to May's notes yet - will resend.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION  ING	` '	TE SURVEY MPLETED
STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 50081  TAG  TAG  F756  Continued From page 41 5/18/23: Recommendation: antidepressant gradual dose reduction (GDR) 6/20/23: GDR not responded to yet; will send to new DON. 7/25/25:21: Fluoxetine (antidepressant) GDR resent. 8/29/23: No response to previous antidepressant gladual dose reduction (GDR) 8/20/23: GDR not responded to yet; will send to new DON. 7/25/25:21: Fluoxetine (antidepressant) GDR resent. 8/29/23: No response to previous antidepressant gladual dose of depression and paranoid personality disorder.  R18's quarterly MDS assessment dated 7/6/23, indicated R18 had moderately impaired cognition and required limited assistance of staff when moving about the facility in a wheelchair.  R18's physician orders included multiple scheduled medications and to consult with pharmacy and health care provider to consider dosage reduction when clinically appropriate.  Review of consultant pharmacist progress notes in the EMR, indicated the following repeat requests to provider: 5/18/23: Resending psych GDR from March. 6/20/23: No response to last months notes yet. 77/25/23: No response to May's notes yet. will resend.  During an interview on 8/30/23 at 11:09 a.m., the			245593	B. WING		08	C /31/2023
GOOD SAMARITAN SOCIETY - ST JAMES  SIJMMEN, MN 58081  SIJMMEN, MN 58081  FROUDERS PLAN OF CORRECTION RECULATORY OR LSC IDENTIFYING INFORMATION)  F 756  Continued From page 41  -5/18/23: Recommendation: antidepressant gradual dose reduction (GDR)  -6/20/23: OR not responded to yet; will send to new DON.  -7/25/23: Fluoretine (antidepressant) GDR resent.  -8/29/23: No response to previous antidepressant antidepressant GDR yet - will resend.  R18's facesheet printed on 8/31/23, included diagnoses of depression and paranoid personality disorder.  R18's quarterly MDS assessment dated 7/6/23, indicated R18 had moderately impaired cognition and required limited assistance of staff when moving about the facility in a wheelchair.  R18's physician orders included multiple scheduled medications and to consult with pharmacy and health care provider to consider dosage reduction when chinically appropriate.  Review of consultant pharmacist progress notes in the EMR, indicated the following repeat requests to provider:  -5/18/23: Resending psych GDR from March6/20/23: No response to last months notes yet7/25/23: No response to May's notes yet. will resend8/29/23: Antipsychotic GDR.	NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	<u> </u>	70172020
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 756  Continued From page 41  -5/18/23. Recommendation: antidepressant gradual dose reduction (GDR)  -6/20/23: GDR not responded to yet; will send to new DON.  -7/25/23: Fluoxetine (antidepressant) GDR resent.  -8/29/23: No response to previous antidepressant Gradual dose reduction (GDR)  -8/29/23: No response to previous antidepressant GDR yet - will resend.  R18's facesheet printed on 8/31/23, included diagnoses of depression and paranoid personality disorder.  R18's quarterly MDS assessment dated 7/6/23, indicated R18 had moderately impaired cognition and required limited assistance of staff when moving about the facility in a wheelchair.  R18's physician orders included multiple scheduled medications including an antipsychotic and antidepressant.  R18's care plan with revised date of 7/25/23, indicated R18 was on antipsychotic and antidepressant medications and to consult with pharmacy and health care provider to consider dosage reduction when clinically appropriate.  Review of consultant pharmacist progress notes in the EMR, indicated the following repeat requests to provider:  -5/18/23. Resending psych GDR from March6/20/23. No response to last months notes yet7/25/23: No response to May's notes yet - will resend8/29/23: Antipsychotic GDR.  During an interview on 8/30/23 at 11:09 a.m., the	GOOD S	AMARITAN SOCIETY	- ST JAMES				
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		5/18/23: Recomm gradual dose reduce6/20/23: GDR not new DON7/25/23: Fluoxetin resent8/29/23: No responsantidepressant GDI R18's facesheet pridiagnoses of depredisorder.  R18's quarterly MD indicated R18 had mand required limited moving about the face R18's physician orders and antidepressant medicated R18 was antide	rendation: antidepressant tion (GDR) responded to yet; will send to be (antidepressant) GDR anse to previous R yet - will resend.  Inted on 8/31/23, included ssion and paranoid personality S assessment dated 7/6/23, moderately impaired cognition d assistance of staff when acility in a wheelchair.  Iters included multiple ons including an antipsychotic and dications and to consult with the care provider to consider when clinically appropriate.  In the pharmacist progress notes the following repeat respect to the following repeat respect to the set of the following repeat respect to the set of the following repeat respect to the following repeat respect to the following repeat respect to last months notes yet the set of May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to May's notes yet - will set of the following repeat respect to the following repeat respect t				
		During an interview	on 8/30/23 at 11:09 a.m., the				

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	PROVIDER OR SUPPLIER	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CO 1000 SOUTH SECOND STREET ST JAMES, MN 56081	<u> </u>	70/31/2023
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F 756	been routed to a prestarted in June 202 interim position in Jerealized there had a resident GDR's, and consultant pharmace According to the intinformed her she had consultant recomment been acted upon the progress notes repeated pharmacy conthe progress notes repeated pharmacis interim DON agreed followed up on, but place to do so.  During an interview nurse practitioner (I supposed to give he sheets for her to result this had not occurrent and for pharmacy consult reprovider follow up in CP-C stated when the CP-C spoke to her for pharmacy consult in order for the DOI According to CP-C, stated in order for the DOI According to C	nt recommendations had not ovider for response since she 3. The DON who started an une, stated she recently been no discussions about d subsequently contacted the cist (CP)-C for an update. The derim DON, the CP-C had ad been emailing pharmacy endations to her but they had		756		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION  ING	` '	TE SURVEY MPLETED
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GOOD S	AMARITAN SOCIETY	- ST JAMES		1000 SOUTH SECOND STREET ST JAMES, MN 56081		
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F 756	Continued From pa	ge <b>4</b> 3	F	756		
	DON admitted whe role, there were mainterim DON stated emails which may h	on 8/31/23 at 2:48 p.m., the n she had started the interimination of the she had received many have included pharmacy endations that she did not				
	The facility policy M Review dated 2/10/	ledication Drug Regimen 23, indicated:				
	harm to a resident of hospitalization.	tion errors that could cause or result in resident ential for adverse events.				
	noting any drug irrefor each resident realso complete the resummary QAPI correports will be given services upon complete the actions upon complete the attention of the acted upon.  6. Drug irregularities medical director of nursing solution must design these reports have calendar days of the documented.	will complete a written report gularities or issues of concern eviewed the pharmacist will nedication regimen review nmittee document. Both to the director of nursing pletion of each monthly DRR ew). The reports must be ending physician and the irector and these reports must swill be reported to the d attending physician by the services or designee. all mate someone to ensure that been acted upon within 30 e review and have been				
	-	harmacy report will be se/EMR upon receipt, under				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	NG	COM	E SURVEY  IPLETED
		245593	B. WING		1	C 31/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	8. Regarding psych the location will ensing the location will ensing the location will ensing the location will ensing the location will ensign and sedative hypnore that therapy is necessary in the local record. In a do not use these ty gradual dose reduction the local local line of the local line o	rmacy consultant report. opharmacological medication sure that residents who have armacological medications offices are not given these unless essary to treat a specific osed and documented in the addition, those residents who pes of medications will receive offices of medications of control offices of the design of the design of the open of medications of the open of medications of the open of medication of the open of medications of the open o	F 7			9/29/23

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		245593	B. WING			C 08/31/2023
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F 880		ge 45 en standards, policies, and orogram, which must include,	F 8	80		
	but are not limited to (i) A system of surve possible communical infections before the persons in the facilit (ii) When and to wh	o: eillance designed to identify able diseases or ey can spread to other				
	reported; (iii) Standard and trate to be followed to pre (iv)When and how i resident; including the	ansmission-based precautions event spread of infections; solation should be used for a				
	depending upon the involved, and (B) A requirement the least restrictive posticircumstances.	e infectious agent or organism nat the isolation should be the sible for the resident under the				
	must prohibit employed disease or infected contact with resider contact will transmit (vi)The hand hygier	ces under which the facility yees with a communicable skin lesions from direct its or their food, if direct the disease; and ne procedures to be followed direct resident contact.				
		tem for recording incidents facility's IPCP and the aken by the facility.				
		ndle, store, process, and as to prevent the spread of				
	§483.80(f) Annual r	eview.				

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		` '	E SURVEY IPLETED
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Continued From pa	ge <b>4</b> 6	F 88	30		
The facility will cond IPCP and update the This REQUIREMENT by:  Based on interview facility failed to ension comprehensive montracked to identify the spread of illness potential to affect a facility.  Findings include:  During an interview the interim director nurse (RN)-A who we preventionist (IP) at IP. Each had recent facility: DON in June 2023RN-B in July 2023RN-A in August 2023	duct an annual review of its leir program, as necessary. NT is not met as evidenced and document review, the ure consistent and inthly surveillance data was rends and patterns to reduce and infection. This had the lilipate 25 residents residing in the on 8/31/23 at 11:07 a.m., with of nursing (DON), registered was also the current infection and (RN)-B who was the former thy started employment at the started employment at the the facility in April 2023 and on of infection surveillance. In a RN-B verified no infection en conducted since they the RN-B stated she had an online tracking tool from the RN-B displayed the tracking Log, on a computer monitor. In pulled data from the facility record (EMR), but neither she yet to work with it. RN-B		1)What corrective actions(s) will accomplished for those residents have been affected by the deficie practice.  The RN hired for the Infection Presention Preventionist Training C 9/19/23. This Infection Prevention since been trained on tracking surveillance to identify trends and patterns, and reporting findings to weekly IDT clinical meeting and r QAPI to ensure compliance.  2)How you will identify other resident having the potential to be affected same deficient practice and what corrective action will be taken.  All residents have the potential to affected by this deficient practice infection prevention RN complete CDC Nursing Home Infection Preventionist Training Course 9/1 This Infection Prevention RN was to complete consistent and comprehensive monthly surveillate to track trends and patterns to respread of illness and infection by via The Good Samaritan Society prevention tracking tool along with the consistent and comprehensive tracking tool along with the consistent and comprehensive monthly surveillanged to track trends and patterns to respond to the consistent and comprehensive monthly surveillanged to track trends and patterns to respond to the consistent and comprehensive monthly surveillanged to track trends and patterns to respond to the consistent and comprehensive monthly surveillanged to track trends and patterns to respond to the consistent and comprehensive monthly surveillanged to track trends and patterns to respond to the consistent and comprehensive monthly surveillanged to track trends and patterns to respond to the consistent and comprehensive monthly surveillanged to track trends and patterns to respond to the consistent and comprehensive monthly surveillanged to track trends and patterns to respond to the consistent and th	found to nt evention Home ourse RN has the nonthly lents d by the d her 9/23. trained nce data duce the 9/19/23 infection n	
stated the facility co	rporation was involved		continuously updated spreadshee	ets.	
	Continued From particles and update the This REQUIREMENT of the spread of illness potential to affect a facility.  Findings include:  During an interview the interim director nurse (RN)-A who we preventionist (IP) and IP. Each had recent facility:  -DON in June 2023RN-B in July 2023RN-A in August 2014 According to the interim DON at surveillance had be started employment recently received and facility corporation. Tool, titled Infection RN-B stated the log electronic medical in nor RN-B stated the facility corporation.	AMARITAN SOCIETY - ST JAMES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 46  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 interview and document review, the facility failed to ensure consistent and comprehensive monthly surveillance data was tracked to identify trends and patterns to reduce the spread of illness and infection. This had the potential to affect all 25 residents residing in the facility.  Findings include:  During an interview on 8/31/23 at 11:07 a.m., with the interim director of nursing (DON), registered nurse (RN)-A who was also the current infection preventionist (IP) and (RN)-B who was the former IP. Each had recently started employment at the facility:  —DON in June 2023 —RN-B in July 2023 —RN-B in July 2023 —RN-A in August 2023  According to the interim DON and RN-B, the previous IP had left the facility in April 2023 and left no documentation of infection surveillance. The interim DON and RN-B verified no infection surveillance had been conducted since they started employment. RN-B stated she had recently received an online tracking tool from the facility corporation. RN-B displayed the tracking tool, titled Infection Log, on a computer monitor. RN-B stated the log pulled data from the facility electronic medical record (EMR), but neither she nor RN-A had time yet to work with it. RN-B stated the facility corporation was involved remotely but no one had been monitoring	A. BUILDII  245593  B. WING_ PROVIDER OR SUPPLIER  AMARITAN SOCIETY - ST JAMES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 46  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 interview and document review, the facility failed to ensure consistent and comprehensive monthly surveillance data was tracked to identify trends and patterns to reduce the spread of illness and infection. 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RN-B stated the facility corporation was involved remotely but no one had been monitoring	PROVIDER OR SUPPLIER  AMARITAN SOCIETY - ST JAMES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 46  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 interview and document review, the facility failed to ensure consistent and comprehensive monthly surveillance data was tracked to identify trends and patterns to reduce the spread of illness and infection. This had the potential to affect all 25 residents residing in the facility.  During an interview on 8/31/23 at 11:07 a.m., with the interim director of nursing (DON), registered nurse (RN)-A who was also the current infection preventionist (IP) and (RN)-B who was the former IP. Each had recently started employment at the facility.  —DON in June 2023  —RN-B in July 2023  According to the interim DON and RN-B, the previous IP had left the facility in April 2023 and left no documentation of infection surveillance.  The interim DON and RN-B verified no infection surveillance had been conducted since they started employment. RN-B stated she had recently received an online tracking tool, titled Infection Log, on a computer monitor. RN-B stated the log pulled data from the facility colporation. RN-B displayed the tracking tool, titled Infection Log, on a computer monitor. RN-B stated the facility corporation was involved remotely but no one had been monitoring	AMARITAN SOCIETY - ST JAMES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 46  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 interview and document review, the facility failed to ensure consistent and comprehensive monthly surveillance data was tracked to identify trends and patterns to reduce the spread of illness and infection. This had the potential to affect all 25 residents residing in the facility and (RN)-B who was the former IP. Each had recently started employment at the facility.  During an interview on 8/31/23 at 11:07 a.m., with the interim director of nursing (DON), registered nurse (RN)-A who was as so the current infection preventionist (IP) and (RN)-B who was the former IP. Each had recently started employment at the facility:  —DON in June 2023 —RN-B in July 2023 —RN-B in Gournel and RN-B verified no infection surveillance had been conducted since they started employment. RN-B stated she had recently received an online tracking tool, titled infection Log, on a computer monitor. RN-B stated the log pulled data from the facility corporation. RN-B displayed the tracking tool, titled infection Log, on a computer monitor. RN-B stated the log pulled data from the facility corporation. RN-B displayed the tracking tool, titled infection Log, on a computer monitor. RN-B stated the log pulled data from the facility corporation. RN-B displayed the tracking tool of the infection prevention RN was trained to complete consistent and comprehensive monthly surveillance to the pulled data from the facility corporation was involved remotely but no one had been monitoring

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				ST JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	Program policy date purpose was to est infection prevention designed to provide comfortable enviror development and tradiseases and infection program. The program	n Prevention and Control ed 10/21/2022, indicated its ablish and maintain an and control program a safe, sanitary, and ment and to help prevent the ransmission of communicable tions. Each facility would on prevention and control ram would attempt to meet egulations for infection control	F 88	what systemic changes will you ensure that the deficient practi recur.  To ensure systemic changes a sustained, the organization solution is linection Preventionist has been and is current. The current Inference policy and procedure on tracking reduce the spread of illness are on 9/28.  4) How the corrective actions (somonitored to ensure deficient procedure, i.e., what quality assome program will be put into practice. Director of Nursing or designed the monthly data to ensure it he completed each month. Will also for 3 months and review at each meeting to ensure compliance.	ce does not re colicy n reviewed ction l on this ng to d infection  will be ractice will urance e. will audit as been dit monthly h QAPI	
<b>F 882</b> SS=F	Infection Prevention CFR(s): 483.80(b)(	nist Qualifications/Role 1)-(4)	F 88	29, 2023. 82		9/29/23
	individual(s) as the	n preventionist esignate one or more infection preventionist(s) (IP) sible for the facility's IPCP.				
		e primary professional training technology, microbiology, her related field;				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	` '	E SURVEY PLETED
		245593	B. WING			C <b>31/2023</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP COD  1000 SOUTH SECOND STREET  ST JAMES, MN 56081	<u> </u>	01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOL) CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION SHOOL (BACH CORRECTIVE ACTION SHOOL)	IOULD BE	(X5) COMPLETION DATE
F 882	Continued From pa	ige 48	F 8	82		
	§483.80(b)(3) World facility; and §483.80(b)(4) Have	ualified by education, training, fication;  at least part-time at the completed specialized prevention and control.				
	This REQUIREMENT by: Based on interview facility failed to ensign preventionist (IP) he training in infection	NT is not met as evidenced  y and document review the ure the acting infection ad completed specialized prevention and control. This affect all 25 residents residing		1)What corrective actions(s) vaccomplished for those reside have been affected by the definentice.  The infection prevention RN content CDC Nursing Home Infect Preventionist Training Course.	nts found to cient ompleted ion	
	a.m., with the interi registered nurse (R IP and (RN)-B who	onducted on 8/31/23 at 11:07 m director of nursing (DON), (N)-A who was also the current was the former IP. Each had ployment at the facility over ths.		2)How you will identify other rehaving the potential to be affected same deficient practice and who corrective action will be taken.  All residents have the potential affected by this deficient practice.	ted by the hat	
	training in infection had been taking cocompleted them. There were no other	prevention and control. Both urses but neither had he interim DON confirmed individuals specialized in and control employed at the		infection prevention RN complete CDC Nursing Home Infection Preventionist Training Course  3)What measures will be put in what systemic changes will you ensure that the deficient practice.	eted her 9/19/23. n place or u make to	
	10/2/22, indicated t	n Preventionist policy dated he facility must designate one as the Infection Preventionist		To ensure systemic changes a sustained, the organization ☐s Infection Preventionist has been	policy	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245593	B. WING				31/ <b>2023</b>
NAME OF F	PROVIDER OR SUPPLIER	24000			TREET ADDRESS, CITY, STATE, ZIP CODE	00/3	01/2023
GOOD S	AMARITAN SOCIETY	- ST JAMES			000 SOUTH SECOND STREET T JAMES, MN 56081		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 882	in nursing, medical epidemiology, or othe qualified by education certification.  -The IP must be quexperience, or certification prevention prevention completed by completed infection prevention.	primary professional training technology, microbiology, ner related field and be on, training, experience, or ualified by education, training, fication. Dete specialized training in and control. In any be ting the CDC course for LTC nist.	F 8	82	and is current. The facility will ensure Infection Prevention RN will be cert the CDC before employment. This education was provided to the RN to become the facility so IP RN and RN became certified by the CDC 9.  4) How the corrective actions(s) will monitored to ensure deficient pract not recur, i.e., what quality assuran program will be put into practice.  Facility will audit the certification of Infection Prevention RN annually to ensure it remains up to date and the the facility remains in compliance.  5) The date of compliance is Septem 29, 2023.	training that /19/23.  be tice will ce the orefore	

PRINTED: 10/11/2023 FORM APPROVED

Minnesota Department of Health

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED
	00697	B. WING		C 08/31/2023
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
COOD CAMADITAN COCIETY	1000 SO	UTH SECOND		
GOOD SAMARITAN SOCIETY	- ST JAMES ST JAME	S, MN 56081		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERT	D BE COMPLETE
2 000 Initial Comments		2 000		
*****ATTE	NTION*****			
NH LICENSING	CORRECTION ORDER			
144A.10, this corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.			
corrected requires of the number and MN Rule with any of the lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all rule provided at the tag ale number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
that may result from orders provided that the Department witl	hearing on any assessments non-compliance with these to a written request is made to hin 15 days of receipt of a ent for non-compliance.			
conducted at your faminnesota Department facility was NOT in Licensure and the fassued. Please indicates	rs: A a licensing survey was facility by surveyors from the nent of Health (MDH). Your compliance with the MN State following correction orders are cate in your electronic plan of a reviewed these orders and			

Minnesota Department of Health

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

(X6) DATE TITLE

**Electronically Signed** 

STATE FORM

09/29/23

If continuation sheet 1 of 26

6899

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2 000 Continued From page 1 identify the date when they will be completed.  The following complaints were reviewed during the survey: H55934716C (MN00093255), H55934720C (MN00095577), H55934764C (MN00091614), H55934765C (MN00093820) H55934766C (MN00091898), H55934766C (MN00091898), H55934776C (MN00091864) and NO licensing orders were issued. 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.	AND PLAN OF C	ORRECTION	IDENTIFICATION NUM		` ,	E CONSTRUCTION	COMP	SURVEY
GOOD SAMARITAN SOCIETY - ST JAMES  (X4) ID PROVIDERS PLAN OF CORRECTION (EACH DEPRICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 000 Continued From page 1 identify the date when they will be completed.  The following complaints were reviewed during the survey: H55934717C (MN00095578), H55934718C (MN0009325), H55934720C (MN00091898), H5593476C (MN00091898), H5593476C (MN00091898), H5593476C (MN00091864) and NO licensing orders were issued.  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.			00697		B. WING			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 000  Continued From page 1 identify the date when they will be completed.  The following complaints were reviewed during the survey: H55934712C (MN00093578), H55934718C (MN00093578), H55934764C (MN0009164), and NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to 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.	NAME OF PROV	IDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
### REGULATORY OR LSC IDENTIFYING INFORMATION)  2 000 Continued From page 1 identify the date when they will be completed.  The following complaints were reviewed during the survey: H55934717C (MN00095578), H55934718C (MN00093255), H55934720C (MN00095577), H55934765C (MN0009389), H55934766C (MN00091898), H55934766C (MN00091898), H5593476C (MN00091864) and NO licensing orders were issued. 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.	GOOD SAMA	ARITAN SOCIETY	- ST JAMES					
identify the date when they will be completed.  The following complaints were reviewed during the survey: H55934717C (MN00093578), H55934718C (MN00093255), H55934720C (MN00095577), H55934764C (MN00091614), H55934765C (MN00093820) H55934766C (MN0009188), H5593476C (MN00091864) and NO licensing orders were issued.  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.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY I	FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	COMPLETE
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a> The State licensing orders are delineated on the attached Minnesota 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	ide The the H5 (MI H5 (	e following compositive survey: H55934718C (MNO N00095577), H5 5934765C (MNO N00091898), H5 d NO licensing of the state Licensing leral software. Taking Homes. The state state and replace in the "Summe umn and replace in the "Summe umn and replace in the state state after the state evidence by." For the Suggested in the Suggested in the Suggested in the Suggested in the state evidence by." For the Suggested in the state evidence i	en they will be completed into were reviewed 717C (MN00095578) 0093255), H55934725934764C (MN000910093820) H559347665934787C (MN000910093820) H559347666 in the feath is document of Health in a state statutes/rule out of complete the "To Comply" por the inviolation of the state in violation of the state in the element of Health in a state mn.us/facilities and the state in the State I and the attached Milth orders being submediate in the box avaination in the state in the electrocess, under the heading in the electrocess.	during ), 20C 1614), 6C 1864) Imenting sing es for per D Prefix liance is iciencies" ortion of cludes state not met s findings and  ctronic ent with  s/regulati icensing innesota nitted to correction ease ailable for onic ing	2 000			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		00697	B. WING			C <b>31/2023</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	STATE, ZIP CODE	1 00/0		
GOOD S	AMARITAN SOCIETY	- ST JAMES 1000 SC	OUTH SECONE	STREET			
		ST JAM	ES, MN 5608 <sup>2</sup>				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	Minnesota Departm	nent of Health.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAL IS NO REQUIREME CORRECTION FOR MINNESOTA STAT http://www.health.st obul.htm. The State delineated on the at Department of Heal you electronically. It is necessary for State enter the word "CO available for text. You electronic State lice heading completion be corrected prior to the Minnesota Depa is enrolled in ePOC	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES. tate.mn.us/divs/fpc/profinfo/in e licensing orders are					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, IN OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.					
2 300	MN Rule 4658.0105	5 Competency	2 300			9/29/23	
	are able to demons techniques necessa needs, as identified	st ensure that direct care start trate competency in skills and ary to care for residents' through the comprehensive nts and described in the					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b>l</b> `´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				A. BUILDING:	<del></del>		
		00697		B. WING		08/3 <sup>2</sup>	: 1/2023
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			1000 SOU	TH SECONE	STREET		
GOOD S	AMARITAN SOCIETY	- ST JAMES		S, MN 56081			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE	 S	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	`	MUST BE PRECEDED BY SC IDENTIFYING INFORMA		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 300	Continued From pa	ge 3		2 300			
	comprehensive plan	n of care, and are ab	le to				
	perform their assign	•					
	This MN Requirements	ent is not met as evi	denced				
		and document revie	w, the		Corrected.		
		ure agency nursing a	,				
		propriate orientation					
	training prior to starting their first shift caring for residents. This had the potential to affect all 25 residents residing in the facility.						
	residents residing if	i tile lacility.					
	Findings include:						
	On 8/29/23 at 2:36	p.m., agency nursing	assistant				
		acility used a lot of a	•				
		ng NA's. NA-A state	•				
		r prior to their sched					
		ur of orientation befo ir own. NA-A stated	•				
		ne to show and expla					
	_	ated when she arrive					
	, ,	st shift, she was prov					
		included resident's r					
		. NA-A stated the fa	•				
	· •	of the facility, residen	•				
	,	r status of the reside quipment, and was	,				
		nic medical record (E					
		, NA-A stated the sta	,				
	trained her was and	other agency staff wh	o was not				
		ility and stated, "I ha	-				
		A-A stated the facility					
		check sheet. NA-A s					
		now residents transfe on status on the resid					
		each resident room					
		wall with information					
		on status. NA-A state					
		e board as well to de					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00697		B. WING			C <b>31/2023</b>
	PROVIDER OR SUPPLIER	- ST JAMES	1000 SOL	DRESS, CITY, S  ITH SECONE  S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 300	Continued From parcares for residents.  On 8/30/23 at 1:55 facility staff and had months. NA-B state facility specific train the facility mechanic observed agency N shower chair lifts or lifts, and would interest assist agency staff.  On 8/31/23 at 8:39 nursing (DON) stated before the start of the facility tour and share hour. The interim Don stated before the start of the facility tour and share hour. The interim Don stated be trained on facility included equipment know a resident's a specific information facility used an orie staff and new facility.  On 8/31/23 at 8:55 (TMA)-A stated the indicated a resident resident specific information facility used an orie staff and new facility.  On 8/31/23 at 8:55 (TMA)-A stated the indicated a resident resident specific information facility used an orie staff and new facility.  On 8/31/23 at 8:55 (TMA)-A stated the indicated a resident resident specific information facility used an orie staff and new facility.  On 8/31/23 at 8:55 (TMA)-A stated the indicated a resident specific information facility used an orie staff and new facility.  On 8/31/23 at 8:55 (TMA)-A stated the indicated a resident specific information facility used an orie staff and new facility.	p.m., NA-B stated so worked at the facing and were not facilifts, and stated A's not sure how to the slings for the near when observed a.m., the interim direct the staff schedulation for agency NA's came agency NA's came agency NA's came acted from facility so staff member. The nursing staff came ashift for orientation, agency staff were a specific information, and would use the mbulation status are interim DON and the interim DON attain the checklist for y staff.  a.m., trained medical staff.	lity for six not receive miliar with she had use the nechanical red to  rector of ler was NA's. The one hour given a during that hour staff and interim in two The expected to he had resident stated the ragency cation aide staff and staf				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00697		B. WING		l	C <b>31/2023</b>
NAME OF PROV	IDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 00/	J 1/2020
GOOD SAMA	RITAN SOCIETY	- ST JAMES		TH SECONE			
OOOD OAM				S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 300 Co	ntinued From pa	ge 5		2 300			
and star for school star che star the	d was responsibled agency NA of one hour prior to neduling coordinate checklist for agency the orientation of the orientation of the resident	she started her perior to agency staffortion time was the NA's shift. The stated she was a tour of the dent transfers, and the occasions where to access the EM a.m., during a form.	ing, and as scheduled he as not aware tion, and he building, and safety R during				
had the exp exp NA with cor of a sor we car pre	d not provided age orientation check bected. The interpretation that age duties, had a central from the facility agency staff. The netimes agency re assigned to the fee. The interim D	n DON confirmed gency NA's or nurshist for agency sim DON stated it ency NA's were certain skill set and nent. The interimity utilized a signification of the facility to provide facility to provide the only stated that was times they were railable.	sing staff taff as was her ompetent in were familiar DON cant number ted ly staff who de resident as not				
adr to u inte pra this re-i	ministrator stated utilize the oriental erim administrator of the color of the oriental erime, and stated implement the oriental erime.	a.m., the intering agency staff were tion check list. He agency confirmed the factorial depends of the factorial depends	re expected owever, the acility current heck list at ould st.				
cor	ntacted workers v	nent dated 8/22/2 will not use facility ervices unless co	equipment				

Minnesota Department of Health

STATE FORM 532E11 If continuation sheet 6 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	l \ /	E SURVEY PLETED
	00697	B. WING			C <b>31/2023</b>
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ΓΑΤΕ, ZIP CODE	•	
	1000 SOU	TH SECOND	STREET		
GOOD SAMARITAN SOCIETY	- ST JAMES ST JAMES	S, MN 56081			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 300 Continued From pa	ge 6	2 300			
•	example) using lift equipment Checklist will be utilized per				
signed 10/12/18, including time prior to all first Assignments and Control, including HIPAA transport of the prior to all first Assignments and Control, the time prior to all first Assignments and Control, infection control, the time prior to all first and Control, the time prior to all first Assignments and Control infection to all first Assignments a	nent with staffing agency-F dicated one hour of orientation shift. Drientation will include, but will ate and federal regulations, ining Employee Right to Know, ts, a written test which or the duties they will perform, arting, vulnerable adult laws, ies, safety in resident care, e agency will provide the tion materials upon request.				
other contingent sta 9/21, indicated: -Please return the a within 48 hours of y assignment with Go very important this is required complia Purpose: the intent an accelerated exp Audience: Good Sa care contingent lab staff Scope: the continge unsupervised only a completed. Agency training (co organization, identification, identificat	aff orientation check list dated attached orientation check list dated attached orientation check list our traveler starting their ood Samaritan Society. It is document is complete, as this nee item.  of this orientation is to provide erience for contingent labor amaritan Society long term or CNA and other contingent ent labor can perform tasks after competency validation is mpleted prior to start): intro to fication, incident/accident ety and OSHA standards, ce, documentation, abuse, ation elder Justice Act azard communication, ction control, BBP, TB,				

NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - ST JAMES  STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
GOOD SAMARITAN SOCIETY - ST JAMES 1000 SOUTH SECOND STREET	023
GOOD SAMARITAN SOCIETY - ST JAMES 1000 SOUTH SECOND STREET	
GOOD SAMARITAN SOCIETY - ST JAMES	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) DMPLETE DATE
2 300 Continued From page 7	
dementia management, advanced directives, preventing unnecessary hospitalization. Roles and responsibilities: review how to log on using Quick Badge shift routines, assignments, responsibility and resident care plans breaks/phone policies real times, feeding, nourishment, hydration reporting to nurse and/or supervisor oxygen safety restraints with return demonstration of quick release snap if applicable to location call light, incontinence products supplies nursing assistant documentation PPE donning and doffing complete hand hygiene and hand washing checklist complete safe and building equipment competency validation checklist facility/unit tour l'm in unit with preceptor  SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for newly hired or supplemental agency nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			SURVEY LETED		
		00697		B. WING		08/3	; 1/2023
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- ST JAMES		TH SECONE S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE  MUST BE PRECEDE  SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 300	Continued From pa	ge 8		2 300			
	(21) days.						
2 550	MN Rule 4658.0400 Resident Assessme	•	ehensive	2 550			9/29/23
	Subp. 4. Review of home must examine quarterly and must comprehensive ass continued accuracy	e each resident a revise the reside essment to ensu	at least nt's ire the				
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the current status and needs for 1 of 1 resident (R21) reviewed for accuracy of the MDS assessment.			Corrected.			
	Findings include:						
	R21's quarterly Minassessment dated admitted on 2/20/23 behaviors, required with bed mobility, transist with dressing hygiene; utilized a vincluded: bipolar dis PTSD, chronic pain weakness, difficulty	5/25/23, indicated by had intact cognitive two-person physical ansfers; two-person person to let use and personder, psychotic syndrome, musical syndrome, musical angles.	d R21 was nition, no sical assist son physical ersonal oses disorder,				
	R21's admission MI indication R21 and intellectual disability	a serious mental	illness and/or				
	On 8/30/23 at 1:17 and interim director		` ,				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED		
		00697		B. WING			C <b>31/2023</b>
	PROVIDER OR SUPPLIER	- ST JAMES	1000 SOU	DRESS, CITY, S  ITH SECONE  S, MN 56081			
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2 550	Section A of the MD staff. RN-A stated stacility as the MDS nurse had complete her start date at the confirmed R21's ad had not been accur documentation of second administrator verificated R21's president review to had not completed. The facility MDS 3.0 (Resident Assessm 6/13/23, indicated: 2. During the obsermember will review is accurate documentation of extending the MDS. Each local state-specific documentation in the PN - MD medical record the information, then a the PN - MDS as particularly as parti	S was completed he recently been nurse, and anothed the admission of facility. The intermission MDS as ately coded and erious mental illings, and should admission screed ave a serious mentation stated the MDS nurse and by on site facility. O (Minimum Data ent Instrument) of the EMR to determine to the assessment of the assessment of the assessment of the supportive documents to determine to the assessment of the supportive documents to determine the supportive documents to determine the supportive documents to determine the supportive documents to the assessment of the supportive documents of the supportive doc	hired at the ner unknown MDS prior to rim DON sessment lacked ness.  In ion MDS had dhad ning and ental illness. facility had at R21's MDS staff.  Is Set) RAI policy dated them ermine if there are coding for review ements and ental index and ental index entation does ent reference for coding umentation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the ends conflicting ill be written in tive entation wing the entation wing t	2 550			

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1000 SOUTH SECOND STREET	
GOOD SAMARITAN SOCIETY - ST JAMES  ST JAMES, MN 56081	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRE	(X5) OMPLETE DATE
2 550 Continued From page 10 2 550	
11. The MDS coordinator will complete a validation verification of the entire MDS. Any errors or warnings must be reviewed and acknowledged.  12. The RM MDS coordinator/ RN Designee will sign and date the MDS signifying it as complete at 20500. This date cannot be prior to the assessment reference date.  13. For comprehensive MDSs: a. After the MDS is completed by each discipline, each discipline will electronically complete the appropriate CAA documentation and CAA Summary. b. The RN MDS coordinator/ RN Designee will electronically sign V020081 and date V020082 signifying completion of the RAI process. c. Care Plan Review - PN must be completed by each discipline after each MDS is signed as completed. The care plan is reviewed with each MDS completion, with the exception of the 5-day and 14-day if the initial care plan has not been completed yet. d. The care plan coordinator will electronically sign V0200C1 and date V0200C2 signifying completion of the care plan process.  The facility Pre-Admission Screening and Resident Review (PASARR) policy dated 12/21/22, indicated: Purpose To determine admission criteria for residents with mental illness and/or mental retardation To ensure that individuals retardation serious mental disorder or intellectual disability receive the care and services they need and the most appropriate setting.  Before Admission: 5. The level II PASARR screening is conducted by the agency designated by the state. The screening will determine whether the prospective	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	` '		SURVEY	
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2 550	Continued From pa	ge 11	2 550			
	resident requires the the location weather specialized services.  SUGGESTED MET The director of nurse review and revise performing Minimassessments and the information. The director of nurse should educate statichanges and audit or records to determinassessments. Audit specific. The results taken to the QAPI of compliance or the new complex compl	e level of services provided the individual requires  HOD OF CORRECTION: sing (DON) or designee coulolicies and procedures related the collection of required ector of nursing or designee to the policy or procedure other residents medical	ld ted e			
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			9/29/23
	home must establis	n control program. A nursing the and maintain an infection signed to provide a safe and the nt.				
	by: Based on interview facility failed to ensure comprehensive months tracked to identify the spread of illness.	and document review, the ure consistent and nthly surveillance data was rends and patterns to reduce and infection. This had the 125 residents residing in the	e e	Corrected.		

Minnesota Department of Health

STATE FORM 532E11 If continuation sheet 12 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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21375	Continued From pa	ge 12	21375			
	Findings include:  During an interview the interim director nurse (RN)-A who was preventionist (IP) and IP. Each had recent facility: DON in June 2023RN-B in July 2023RN-A in August 2024 According to the interim DON and surveillance had be started employment recently received and facility corporation. Tool, titled Infection RN-B stated the log electronic medical mor RN-A had time stated the facility corporation.	on 8/31/23 at 11:07 a.m., with of nursing (DON), registered vas also the current infection and (RN)-B who was the former tly started employment at the				
	Program policy date purpose was to esta infection prevention designed to provide comfortable enviror development and tradiseases and infection program. The program	Prevention and Control ed 10/21/2022, indicated its ablish and maintain an and control program a safe, sanitary, and ment and to help prevent the ansmission of communicable ions. Each facility would n prevention and control am would attempt to meet gulations for infection control				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED		
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21375	Continued From pa	ge 13		21375			
	where applicable.						
21426	SUGGESTED MET DON (Director of Noreview/revise facility contain all compone program to mitigate infections. The DON all staff on existing perform audits to enfollowed. The resultaken to Quality Assimprovement command the need for fundamental for Condays.  MN St. Statute 1446	ursing) or designed policies to ensure transmission of policies or revised policies and the policies of those audits of those audits of the policies of the policies of those audits of the policies of the policies of those audits of the policies of the policies of those audits of the policies of the po	e should re they n control cotential ald educate and are being should be note e compliance one (21)	21426			9/29/23
	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volumed the shall provide regarding implement (b) Written compliate the maintained by the shall provide the maintained by the shall provide	e provider must est nensive tuberculos ogram according to gram according to gram according to infection control d States Centers tion (CDC), Division ation, as published ality Weekly Report include a tuberculor include a tuberculor not that covers all provident include a tuberculor include a tuberculor	sis to the most guidelines for Disease on of ed in CDC's rt (MMWR). losis paid and ents, rtment of ance elines.				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
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21426	Continued From pa	ge 1 <b>4</b>	21426			
	by: Based on interview facility failed to ensu (trained medication housekeeping (HK) (NA)-B) were propertuberculosis (TB).  Findings include:  TMA-A was hired 1/lacked evidence a stesting was completed.  TMA-C was hired 6/lacked evidence a stesting was completed.  HK-A was hired 3/1/levidence a symptor completed.  NA-B was hired 3/2/lacked evidence a stesting was completed.  On 8/31/23 at 11:36/ladministrator verifier.	A, and nursing assistant only screened and/or tested for 10/23, and record review symptom screening or TB ted.  13/23, and record review symptom screening or TB ted.  23, and record review lacked in screening or TB testing was 8/23, and record review symptom screening or TB testing was symptom screening or TB ted.  3 a.m., the interimed employees TMA-A, TMA-C, and not completed the TB		Corrected.		
	Health Care Setting	sk assessment worksheet for is Licensed by MDH dated he facility performed the				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	1 ` ′	(X3) DATE SURVEY COMPLETED	
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21426	Continued From pa	ge 15	21426				
	required TB screeni at the time of hire.	ing and testing of all personne	el				
	The facility Tubercu Screening for Emplindicated: Purpose: To provide early ide infected with Mycob tuberculosis (TB) to through appropriate employees with TB Policy: New employees will screening and post-according to current guidelines. Procedure Baseline Screening all employees will be signs or symptoms persistent cough (grantion), especially	prevent the spread of TB screening and treatment of or exposure to TB.  I have a baseline TB exposure screening to CDC recommendations and for TB Prior to or upon hire, e screened for TB risk and for active TB disease: reater than three weeks in the presence of other					
	complaints of blood weight loss, anorex	compatible with TB, such as y sputum, night sweats, ia or fever e, all employees will receive a					
	blood test.	skin test (TST) or single TB					
	New employees wit than 30 days old will	h verified results not more Il not be retested					
	,	step Mantoux method should					
	involves administeri	ing the initial test upon hire,					
		48 to 72 hours by a nursing					
		nysician/practitioner. If the first e second test should be					
		weeks after the placement of	:				
	•	state regulations. The second					
	test is read 48 to 72 hours after administration.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	STATE, ZIP CODE	<u>.                                      </u>	
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21426	Two IGRAs have be approved for testing In-Tube test (QFT)  SUGGESTED MET infection control nur (DON) and/or design procedures related for tuberculosis for be educated on the screening, and the The ICN, DON and/or defindings/education to Performance Improva determined amount committee determined the need for ongoin	acceptable form of TB testing. Been G: QuantiFERON-TB Gold T-Spot TB Test (T-spot)  THOD OF CORRECTION: The rese (ICN), director of nursing mee could review policies and to the screening and testing employees. Facility staff could TB regulations, symptom two-step Mantoux process. For designee could audit new I testing for tuberculosis. The resignee could take those to the Quality Assurance wement (QAPI) committee for ant of time until the QAPI mes successful compliance or				
21530	A. The drug regime reviewed at least me currently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lotthe Department of Health Care Finance This standard is incompared available through the system. It is not surveyor surveyor Procedure Requirements in Lotthe Department of Health Care Finance This standard is incompared to the system. It is not surveyor surveyor Procedure Requirements in Lotthe Department of Health Care Finance This standard is incompared to the system. It is not surveyor procedure.	en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ong-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any				9/29/23

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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21530	irregularities to the and the attending possician visit, or so pharmacist. For purupon must be acted upon physician visit, or so pharmacist. For purupon means the acreport and the signit of nursing services.  C. If the attending with the pharmacist believes being adversely affer refer the matter to the if the medical direct physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter assessment and as a session of the medical director must refer the matter assessment and as a session of the medical director must refer the matter assessment and as a session of the medical director must refer the matter assessment and as a session of the medical director must refer the matter assessment and as a session of the medical director must refer the matter assessment and as a session of the medical director must refer the matter assessment and as a session of the medical director must refer the matter to the medical director must be referred for a session of the medical director must be referred for a session of the medical director must be referred for a session of the medical director must be referred for a session of the medical director must be referred for a session of the medical director must be referred for a session of the medical director must be referred for a session of the medical director must be referred for a session of the medical director must be refer	director of nursing hysician, and the property of the time of the consulting by and the attending physician does not the resident's questification, and the resident's questification, are the resident's questification, and the medical director decided director decided director decided and does not have the consulting of the attending physician does not have the consulting of the consultin	se reports ne next d by the rt, "acted rction of the rthe director g physician. es not concur on, or does nd the uality of life is acist must for review nding termines that re adequate ttending r, the matter uality ree required ohysician is pharmacist quality	21530			
	This MN Requirements by: Based on interview facility failed to ensure the recommendations with the for 4 of 5 residents reviewed for unnecessity.	and document re ure consulting ph vere addressed of (R10, R13, R15,	eview, the armacist or acted upon and R18)		Corrected.		
	Findings include: R13's quarterly MDaindicated R13 was a one-person physical	cognitively intact,	required,				

	ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	COMPLETED	
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21530	Continued From pa	ge 18		21530			
	hygiene, utilized a v malnutrition and de indicated scheduled	toilet use, and personal wheelchair, diagnoses in pression, and medication insulate, antidepressant, diur	ncluded ons in				
	multiple scheduled	lers dated 8/31/23, inclumedications which including the distance of the dista	ıded				
	R13's care plan dated 8/31/23, indicated R13 was on medications with FDA boxed warning or warnings of adverse consequences r/t (related to): pain management, diuretic use, antidepressant therapy and HTN (hypertension) treatment; interventions included: consult with pharmacy, healthcare provider, etc. to consider dosage reduction with clinically appropriate.						
	notes in the EMR in requests to provide8/29/23, No response recommendations y7/25/23, resending DON4/14/23, no response	nse to previous  et, will resend again. g clarification of orders. g last month's note to ne	peat				
	indicated R15 had a required, one-personal bed mobility, transfer personal hygiene, undiagnoses included dysfunction, non-Ala	S assessment dated 7/2 a severe cognitive impain physical assistance vers, dressing, toilet use, tilized a wheelchair, non-traumatic brain zheimer's dementia, ychotic disorder, and	irment, vith				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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21530	Continued From particular antipsychotic, antide antipsychotic, antide an antidepressant, antipsychotic medical antipsychotic medical and interventions in pharmacy, healthcar dosage reduction with psychopharmacologic disorder e/b (evider antipsychotic medical included discuss with ongoing for use of recondition based on clinical standards of the EMR in requests to provide 1-6/20/23, No response in the EMR in requests to provide 1-6/20/23, No response in the EMR in requests to provide 1-6/20/23, no respo	ed R15 received epressant medication ders dated 8/31/23, imedications which pain medications, a cation.  ed 8/31/23, indicated the medication r/t deposition and intervention of the clinically approposition and intervention and intervention the health care provinced by) taking an eation and intervention the health care provinced by) taking an eation and intervention of the clinical practice guides and the following the composition of the following received	included included and an	21530			
	R10's physician ord	ers included multip	le				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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21530	Continued From pa	ge 20	21530			
	scheduled medicati antidepressant, ant for anxiety.	ons including an ipsychotic and a medication				
	indicated R10 was a medication and to constant provider and family medication; to constant	h revised date of 7/7/22, on an antidepressant discuss with health care , ongoing need for use of sult with pharmacy and/or r to consider dosage reduction opriate.	7			
	Review of consultant pharmacist progress notes in the electronic medical record (EMR), indicated the following repeat requests to provider:5/18/23: Recommendation: antidepressant gradual dose reduction (GDR)6/20/23: GDR not responded to yet; will send to new DON7/25/23: Fluoxetine (antidepressant) GDR resent8/29/23: No response to previous					
	antidepressant GDR yet - will resend.  R18's facesheet printed on 8/31/23, included diagnoses of depression and paranoid personality disorder.  R18's quarterly MDS assessment dated 7/6/23, indicated R18 had moderately impaired cognition and required limited assistance of staff when moving about the facility in a wheelchair.					
		lers included multiple ons including an antipsychotic				
	indicated R18 was	h revised date of 7/25/23, on antipsychotic and dications and to consult with				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	l ` ′	(X3) DATE SURVEY COMPLETED	
		00697		B. WING			C <b>31/2023</b>
	PROVIDER OR SUPPLIER	- ST JAMES	1000 SOL	DRESS, CITY, S  JTH SECONE  S, MN 56081		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE  MUST BE PRECEDED I  SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
21530	Pharmacy and heal dosage reduction we review of consultar in the EMR, indicate requests to provide5/18/23: Resendir6/20/23: No responses end8/29/23: Antipsych During an interview interim director of number pharmacy consultar been routed to a prestarted in June 202 interim position in June 202 in	th care provider to then clinically apprount pharmacist progred the following regard the following regard the following regard psych GDR from use to last months use to May's notes to May's noting to the EMR; noting at requests for GDI of they should have there had been notes to May's at 10:2 NP)-D stated staff to the may and provide a may a	ress notes beat  March. In March. In Notes yet. Is yet - will  9 a.m., the ed written ins had not e since she tarted an cently is about intacted the ipdateC had charmacy in the R's. The been in process in esponse, were inmendation response,	21530			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		00697		B. WING			C <b>31/2023</b>
	PROVIDER OR SUPPLIER	- ST JAMES	1000 SOU	DRESS, CITY, S TH SECONE  5, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 22		21530			
	During a phone interp.m., CP-C stated so DON (current and for pharmacy consult reprovider follow up in CP-C stated when to CP-C stated when to CP-C spoke to here for pharmacy consustant for the DON According to CP-C, reports had been seen a linear DON admitted when to the pool of t	she had been emailing ormer) each month reports but had not so the EMR for severable DON started in John person about the lit reports and informed DON the reports each to obtain provider the first email with pent to the DON on 6, and started the ny competing priority she had received may be included pharmater and included pharmater in	ng the with een al months. June, process ned her ach month response. pharmacy /20/23.  o.m., the e interimises. The nany acy				
	The facility policy M Review dated 2/10/	edication Drug Regi 23, indicated:	imen				
	Purpose:  -To prevent medical harm to a resident of hospitalization.  - To identify the potential to the potential in the pot	or result in resident					
	Monthly Drug Regings. The pharmacist was noting any drug irrefor each resident realso complete the name of summary QAPI concepts will be given services upon complete the regimen review.	will complete a writte gularities or issues of viewed the pharmad nedication regimen is nmittee document. En to the director of no oletion of each mont	of concern cist will review Both ursing thly DRR				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00697	B. WING		C 08/31/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
COODS	AMADITAN COCIETY	1000 SO	UTH SECONE	STREET		
GOOD S	AMARITAN SOCIETY	- ST JAMES ST JAME	S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
21530	locations medical d	ge 23 ending physician and the irector and these reports must	21530			
	medical director and director of nursing solocation must design these reports have calendar days of the documented.  7. The consultant place and sedation will ensure the location will ensure the location will ensure that therapy is necessary is necessary in the location, as diagnostical record. In a do not use these typical dose reductions and sedation will ensure the location of the location will ensure the location	s clinically contraindicated, in				
	SUGGESTED MET The director of nurs the consulting phare revise policies to me recommendations a nursing (DON) or de pharmacist should on the importance of are acted upon as a should be developed action from physicial timeframe's for a speamount of time. The should take those fire	HOD OF CORRECTION: sing (DON) or designee and macist should develop and/or onitor medications to ensure are acted upon. The director of esignee and the consulting educate physicians and staff of ensuring recommendations on as possible. Audits of to monitor timeliness of an, using appropriate pecific and measurable e DON and/or designee andings/education to the Performance Improvement				

	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			<b>l</b> ` ′	E CONSTRUCTION	COMPLETED	
		00697		B. WING		C 08/31/2023	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES	1000 SOU	TH SECONE	STREET		
	AWARTAN SOCIETY	- OT OANLO	ST JAMES	S, MN 56081			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENT MUST BE PRECEDED INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Continued From page 24			21530			
	(APIA) committee to determine compliance or the need for further monitoring.						
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.						
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils			21942			9/29/23
	Resident advisory of boarding care home advisory council and fewer than three per participating. If one function, the nursing home shall docume council or councils a year. This subdivision residents and familia 144.651, subdivision	e shall establish and a family council received a family councils or both councils and its attempts to at least once each on does not alterness provided by se	resident I, unless I interest in I do not I ng care I establish the I h calendar I the rights of				
	This MN Requirements by: Based on interview facility failed to estathe past 12 months effect all 25 residents	and document real blish a family cou	eview, the uncil within tential to		Corrected.		
	Findings include:						
	On 8/31/23 11:48 a worker verified no a council had been multiple Further SS-A confirmed were required	ttempts to form a ade within the las	a family st 12 months.				
	On 8/31/23, at 11:5	5 a.m. the interim	1				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00697	B. WING		C 08/31/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES	TH SECONE S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
21942	Continued From pa	ge 25	21942			
	family council and s	med the facility did not have a stated there was no had been attempted in the				
	The facility did not processed family council.	provide a policy regarding				
	facility's social work family members via participate in a family frequency of the far determined by the formaintained. If the firm results, the facility of later in the same yeldesignee could more a family council.	HOD OF CORRECTION: The ser could contact resident any method, to invite to say method, to invite to say council meeting. The mily council meetings could be samily council. Documentation attempts should be rest attempt does not yield could make another attempt ear. The administrator or nitor the attempts to organize				



Travis Z. Ahrens 49207

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

F5593034

PRINTED: 09/20/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245593	B. WING			08/31/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - ST JAMES				STREET ADDRESS, CITY, STATE, ZIP CODE  1000 SOUTH SECOND STREET  ST JAMES, MN 56081			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	B 92	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		KC	000			
	FIRE SAFETY						
	conducted by the M Public Safety, State 08/31/2023. At the Samaritan Society- compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National R (NFPA) 101, Life Sa Existing Health Car NFPA 99, the Healt This one-story with determined to be of is fully sprinklered to building was constr- additions in 1965, 1	apacity of 44 beds and had a					
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.