DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 6, 2022

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

RE: CCN: 245207
Cycle Start Date: February 17, 2022

Dear Administrator:

On March 22, 2022, the Minnesota Departments 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 6, 2022

CMS Certification Number (CCN): 245207

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 16, 2022 the above facility is certified for:

68 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 68 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2022

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

RE: CCN: 245207
Cycle Start Date: February 17, 2022

Dear Administrator:

On February 17, 2022, 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:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 238-8786 Mobile (651)238-8786

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 May 17, 2022 (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 August 17, 2022 (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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/14/22 - 2/17/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		3/16/22

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

Electronically Signed | 03/17/2022

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

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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: As a result of the Life Safety Code survey on 2/24/22, and based on documentation review and staff interview, the facility failed to inspect the generator per 2012 edition of the Life Safety	E 041	1. The facility will continue to perform weekly inspections and monthly generator runs and will add an annual load bank test to meet the 30% of the rated Kilowatt	

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E 041	Continued From page 3 Code NFPA 101 section 9.1.3.1 and NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.4, and NFPA 110 the Standard for Emergency and Standby Power Systems, section 8.4.2 and 8.4.2.3. This deficient finding could have a widespread impact on all 37 residents within the facility. Findings include: During inspection of the facility generator by the state fire marshal on 2/24/22, at 9:30 a.m., it was revealed by review of all available emergency generator maintenance and testing documentation and staff interview, the facilities diesel generator was not capable of reaching the 30% of the rated Kilowatt output for the monthly testing. Current documention of annual load bank test was not available. The last documented load bank test was completed on 12/15/2019. An interview with the Director of Environmental Services verified this deficient finding at the time of discovery.	E 041	output test. 2. The scheduled date for the load bank test is Thursday, March 16, 2022 and was performed by Zeigler Cat. 3. The final report will be documented in the TELS preventative maintenance system and reported to the QAPI committee. 4. The Environmental Services Director or designee will be responsible to ensure the schedule is maintained and the documentation is provided and submitted into the TELS preventative maintenance system. 5. The date for the inspection was scheduled on March 14, 2022.	
F 000	INITIAL COMMENTS On February 14,15,16,and 17, 2022, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to not be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be UNSUBSTANTIATED: H5207058 (MN80379).	F 000		

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F 000	Continued From page 4 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of	F 886		2/21/22

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F 886	Continued From page 5 COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 886	Preparation and execution of this	

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F 886	Continued From page 6 facility failed to provide written documentation showing contact tracing had been completed following an outbreak of COVID-19. This had the ability to affect all 36 residents in the facility. Findings include: During an interview on 2/16/22, at 10:41 a.m. the director of nursing (DON) stated the facility was in outbreak status. The outbreak started on 1/29/22, when R5 tested positive for COVID-19. The DON stated the facility did not test all the residents and staff following the COVID-19 outbreak because they chose to do contact tracing. During an interview on 2/16/22, at 1:00 p.m. the administrator verified the facility did not test all residents and staff following an outbreak of COVID-19 because they chose to do contact tracing. She further stated R5 was the first resident who tested positive. R5 had been out in the community with his family and when he returned he was symptomatic and was tested. R5's test results came back positive so the facility used contact tracing to figure out who R5 had close contact with and tested those individuals. The administrator stated the facility performed contact tracing on all 16 residents and staff who tested positive following the outbreak. The administrator further stated they do not have contract tracing logs. During documentation review on 2/17/22, at 11:15 a.m. two binders (one labeled residents, one labeled staff) each contained forms (untitled), which identified 16 residents and staff that were tested and their results; however there was no indication regarding why they were tested or any follow up that was done.	F 886	response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual. F886 Covid-19 Testing-Residents & Staff 1. Close contacts were identified through interview and observation with staff and resident. All residents that were in close contact with positive residents were tested using POC and/or PCR testing. 2. All newly identified positive staff or resident cases will be tracked using the Exposure Risk Worksheet. Those identified as close contacts and/or have had a high risk exposure will be tested for COVID-19 infection per MDH guidelines. All staff will be removed from the schedule until results received. All resident will be placed in isolation until test results are received. 3. LNHA and DNS will start using the Exposure Risk worksheet with the next identified positive staff and/or resident. 4. All new positive cases of COVID-19 infection will be brought to QAPI for review and to ensure contact tracing has been completed and ensure all those	

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F 886	Continued From page 7 During an interview on 2/17/22, at 1:09 p.m. the administrator brought in a book with her notes to demonstrate she had spoken to the employee's who tested positive for COVID-19. She stated she asked each staff member who they had come in contact with and if they were wearing appropriate personal protective equipment (PPE). The administrator also stated it was a small facility and they usually have the same staff. They know which residents come into contact with other residents. She also stated since they've had a problem with staffing "they've gotten lax [sic] on documenting the contact tracing form." According to QSO-20-38 memo last revised 9/10/21, upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based (e.g. facility-wide) testing. If the facility has the ability to identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. When prioritizing individuals to be tested, facilities should prioritize individuals with signs and symptoms of COVID-19 first, then perform testing triggered by an outbreak investigation (as specified below). Table 1: -Newly identified COVID-19 positive staff or resident in a facility that can identify close contacts. -Test all staff, vaccinated and unvaccinated, that had a higher-risk exposure with a COVID-19 positive individual. -Test all residents, vaccinated and unvaccinated, that had close contact with a COVID-19 positive	F 886	identified as close contacts and/or high risk exposures have been tested for COVID-19 infection. 5. Completion Date: 2/21/2022	

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	245207	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 8 individual. The Good Samaritan Society-Stillwater Testing Plan dated 8/3/21, included "If we have an outbreak; one positive test result, we will use contract tracing, as appropriate, to determine who should be tested or if all staff and residents will need to be tested, every 3-7 days until we have 2 rounds of testing with all negative results. It further included a table titled "testing trigger" in which it identified during outbreak status, the facility would test all staff that previously tested negative until no new cases are identified and test all residents that are appropriate and previously tested negative until no new cases are identified.	F 886		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245207	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	**1119 OWENS STREET NORTH STILLWATER, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident status was accurately reflected in the Minimum Data Set (MDS) for 3 of 3 residents (R27, R34, R18) reviewed for anticoagulants. Finding include: Centers for Medicare/Medicaid Service (CMS) long-term care (LTC) resident facility assessment instrument (RAI) 3.0 users manual version 1.17.1 dated 10/19, identified in section "N" medications under coding instructions indicated record the number of days an anticoagulant medication was used by the resident at any time during the 7-day look back period. Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. R27's most recent annual assessment dated 1/4/22, identified R27 received seven (7) days of anticoagulant medication during the look-back period. R27's Order Summary Report, printed 2/17/22 outlined R27 had an order in place for Clopidogrel on a daily basis; however, it lacked any evidence of anticoagulant medication provide to R27 during the same period. R34's most recent admission assessment dated 1/27/22, identified R34 received two (2) days of anticoagulant medication during the look-back period. R34's Order Summary Report, printed 2/17/22 outlined R34 had an order in place for Clopidogrel four (4) times per week; however, it lacked any evidence of anticoagulant medication provide to R34 during the same period. R18's most recent quarterly assessment dated 12/7/21, identified R18 received seven (7) days of anticoagulant medication during the look-back period. R18's Order Summary Report, printed 2/17/22 outlined R18 had an order in place for Clopidogrel on a daily basis; however, it lacked any evidence of anticoagulant medication provide to R18 during the same period. During interview on 2/17/22, at 10:25 a.m. registered nurse (RN)-A verified she was the RN responsible for completing the Minimum Data Set (MDS)(s) for the facility. RN-A stated she was coding Clopidogrel as an anticoagulant. RN-A then reviewed the RAI manual dated 10/2019, and verified it directed not to record Clopidogrel as anticoagulant. The MDS(s) were incorrect and RN-A stated she would modify and resubmit them. A policy on coding medications was requested and the facility provided section "N" titled medications in the RAI manual dated 10/19 which included: Anticoagulant (e.g., Warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Continued From Page 1 during the 7-day look-back period (or since admission/entry or reentry illness than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING **01 - STILLWATER GOOD SAMARITAN** B. WING _____	**02/24/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	**1119 OWENS STREET NORTH STILLWATER, MN 55082**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual fire safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/24/2022. At the time of this survey, Good Samaritan Society - Stillwater was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/17/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society Stillwater is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1962 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(111) construction. In 1992, an addition was constructed to the East side of the building that was determined to be of Type II(111) construction. Because the original building and	K 000		

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	245207	A. BUILDING **01 - STILLWATER GOOD SAMARITAN** B. WING _____	**02/24/2022**

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K 000	Continued From page 2 the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 68 beds and had a census of 37 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		3/15/22

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K 321	Continued From page 3 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 02/24/2022 at 11:30 AM, it was revealed by observation that resident rooms 136 and 142 do not have door closers and are being used as combustible storage rooms. An interview with the Assistant Director of Environmental Services verified this deficient finding at the time of discovery.	K 321	K321-Hazardous Areas-Enclosure 1. Room 136 and room 143 were cleared out and put back into order as a resident room and not used for combustible storage. 2. An inspection was completed on all rooms, including unoccupied resident rooms, to ensure that they were put back in order and not being used for storage. 3. Audits will be completed on a weekly basis to ensure unoccupied resident rooms are not becoming cluttered or used as storage areas. 4. The Environmental Services Director or designee will be responsible to remove clutter, restore room order and maintain room order for compliance. 5. Date of completion March 15, 2022.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		3/14/22

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K 345	Continued From page 4 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/24/2022 at 9:15 AM, it was revealed by a review of available documentation that the semi-annual fire alarm inspection documentation was not available at the time of the survey. An interview with the Assistant Director of Environmental Services verified this deficient finding at the time of discovery.	K 345	K345-Fire Alarm System-Testing and Maintenance 1. Fire Alarm Inspection and Testing was performed and completed on February 25, 2022. Full report is available. 2. The semi-annual Fire Alarm Inspection and Testing is scheduled for August 25, 2022, will be completed by our Environmental Services Department using the inspection document provided by the Fire Marshal, and will be used to maintain compliance with the Life Safety requirement ongoing. 3. The date of inspection will be documented in TELS and reported to the QAPI committee. 4. The Environmental Services Director or designee will be responsible for ensuring the schedule is accurate and the documentation is provided and submitted into TELS preventative maintenance system. 5. Scheduled on March 14, 2022 for testing on August 25, 2022.	
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are	K 353		3/15/22

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K 353	Continued From page 5 maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/24/2022 at 9:20 AM, it was revealed by a review of available documentation the facility did not perform a 2nd quarter flow test of the sprinkler system. An interview with the Assistant Director of Environmental Services verified this deficient finding at the time of discovery.	K 353	K353-Sprinkler Maintenance and Testing 1. The last flow test was completed on February 7, 2022, by Viking Automatic Sprinkler Company. The second quarter flow test will be scheduled with Viking Automatic Sprinkler Company. City water is the water supply source. 2. Worked with Viking Automatic Sprinkler Company to establish a quarterly schedule to maintain compliance with the Life Safety code requirement, date on test is pending and will be in the month of May. 3. The date of inspections will be documented in TELS and reported to the QAPI committee. 4. The Environmental Services Director or designee will be responsible for ensuring the schedule is accurate and the documentation is provided and submitted into TELS preventative maintenance system. 5. Scheduled on March 15, 2022 for quarterly inspections.	

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K 521	Continued From page 6	K 521		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the heating, ventilation, and air conditioning system per NFPA 101 (2012 edition), Life Safety Code, sections 9.2 and 19.5.2.1, and NFPA 90A (2012 edition), Standard for the Installation of Air-Conditioning and Ventilating Systems, section 5.4.8.1 and 5.4.8.2, and NFPA 80 Standard for Fire Doors and Other Opening Protective's (2010 Edition), sections 19.4.1.1, 19.4.9, 19.4.10 and 19.5.5 and NFPA 105 Standard for Smoke Door Assemblies and Other Opening Protective's (2010 Edition), sections 6.5.2, 6.5.11, 6.5.12 and 6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/24/2022 at 09:00 AM, it was revealed by a review of available documentation the facility had exceeded the required four-year testing of the smoke and fire dampers.	K 521	K521-HVAC 1. The four year testing of the smoke and fire dampers has been scheduled with Harris Mechanical to determine where the dampers are located throughout the building. 2. On March 16, Harris Mechanical did an on-site inspection to locate smoke and fire dampers. It was concluded that our location does not have these and no testing can be completed. A report will be written and sent to the Fire Marshal and a copy placed in our Life Safety book for future reference. 3. The final report will be documented in the TELS preventative maintenance system and reported to the QAPI committee. 4. The Environmental Services Director or designee will be responsible to ensure the documentation stating we do not have smoke or fire dampers is provided and submitted into the TELS preventative maintenance system.	3/16/22

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K 521	Continued From page 7 An interview with the Assistant Director of Environmental Services verified this deficient finding at the time of discovery.	K 521	5. Scheduled on March 14, 2022 for the inspection on March 16, 2022.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		3/16/22

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K 918	Continued From page 8 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the generator per NFPA 101 (2012 edition) Life Safety Code, section 9.1.3.1 and NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.2 and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/24/2022 at 09:30 AM, during the review of all available emergency generator maintenance and testing documentation, the facility's diesel generator could not reach 30% of the rated Kilowatt output for the monthly testing. Additionally, the facility could not provide current documentation of a completed annual load bank test in place of the 12 monthly run tests reaching 30%. As a result, the last documented load bank test was conducted on 12/15/2019. An interview with the Assistant Director of Environmental Services verified this deficient finding at the time of discovery.	K 918	K918-Electrical Systems-Essential Electric System Maintenance and Testing 1. The facility will continue to perform weekly inspections and monthly generator runs and will add an annual load bank test to meet the 30% of the rated Kilowatt output test. 2. The scheduled date for the load bank test is Thursday, March 16, 2022 and was performed by Zeigler Cat. 3. The final report will be documented in the TELS preventative maintenance system and reported to the QAPI committee. 4. The Environmental Services Director or designee will be responsible to ensure the schedule is maintained and the documentation is provided and submitted into the TELS preventative maintenance system. 5. The date for the inspection was scheduled on March 14, 2022.	