DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2022

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: June 29, 2022

Dear Administrator:

On July 11, 2022, we notified you a remedy was imposed. On August 12, 2022 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 5, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 29, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 11, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 29, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 5, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 6/26/22 through 6/29/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/26/22 through 6/29/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5279116C (MN73021), with a deficiency cited at F689. The following complaints were found to be UNSUBSTANTIATED: H5279117C (MN78949). 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/21/2022

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
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess ability to self-administer medications for 1 of 1 resident (R29) observed to self-administer a nebulizer treatment. Findings include: R29's admission Minimum Data Set (MDS) dated 4/27/22, indicated R29 had mild cognitive impairment and diagnoses of chronic obstructive pulmonary disease (COPD) and dementia. R29's provider order summary dated 6/29/22, indicated R29 had an order for Albuterol Sulfate Nebulization solution 2.5 milligrams (mg)/3 milliliters (ml) 1 dose via mask one time a day for dyspnea (shortness of breath). Document oxygen saturations, pulse, respirations, and lung sounds pre and post administration and record total time spent with resident on treatment. R29's medical record lacked evidence of R29's ability to self-administer medications.	F 554	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F554 Resident Self-Admin Meds-Clinically Approp (SS=D) 1. R29 was assessed for self-administration of medications and care plan updated on 7/15/22. 2. All residents receiving nebulizer treatments were reviewed on 7/18/22 to ensure self-administration assessments were completed as appropriate.	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 554	Continued From page 2 R29's medication self-administration assessment was requested however was not received. During an observation on 6/29/22, at 7:49 a.m. registered nurse (RN)-A administered R29's oral medications and then set up R29's nebulizer with the albuterol medication as ordered. R29 was up in the wheelchair with the bedside table in front of him. RN-A assessed R29's lungs and obtained vital signs before setting up R29's nebulizer. RN-A stated R29 was "ok to self-administer the nebulizer and just needs set up". RN- further stated an assessment was completed to determine R29's ability to administer, but a provider order was not required. RN-A instructed R29 to close his mouth over the nebulizer to breath and would return when finished. RN-A then left the room at 8:01 a.m. At 8:02 a.m. R29 had set the nebulizer down on the bedside table in front of him and took some sips of water. R29 picked up the nebulizer up for a moment before again setting it back down on the table. R29 then drank some more water and picked up the magazine on his table and started going through the pages. R29's nebulizer remained running while sitting on the bedside table. At 8:07 a.m. RN-A returned and asked if R29 was completed, R29 stated yes. RN-A cleaned the equipment before leaving R29's room. During an interview on 6/29/22, at 8:31 a.m. RN-B stated an assessment was needed to determine a resident's ability to self-administer medications. If the assessment showed the residents ability, a provider order was obtained. RN-B stated R29 would not be able to self-administer medications or nebulizers. RN-B further stated R29 may be able to hold it, but R29 has dementia, and the nurse needed to stay to	F 554	3. The Director of Nursing Services and/or designee will conduct re-education on “Resident Self Administration of Medications” assessment and obtaining physician orders by 8/5/22 for all nurses. Residents that are unable to self-administer nebulizer treatments will have their orders updated to reflect need for supervision while nebulizer is running. 4. The Director of Nursing Services and/or designee will conduct record reviews to ensure all residents receiving nebulizer treatments have been assessed for self-administration and orders accurately reflect neb administration supervision as determined by the assessment. These audits will be conducted daily x2 weeks, then weekly x2, then monthly x2. Audit results will be taken to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 554	Continued From page 3 ensure the medication was administered. During an interview on 6/29/22, at 12:40 p.m. the director of nursing (DON) stated all residents who self-administer medications were required to have an assessment and teaching to determine if the resident was capable of self-administering medications. Once an assessment was completed and determined appropriate, a provider order was obtained. A facility policy titled Resident Self-Administration of Medication, revised 10/15/21, directed staff to complete the resident self-administration of medications assessment, complete an interdisciplinary review, and obtain a provider order prior to self-administering medications.	F 554		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bathing care was provided to 1 of 4 residents (R46) reviewed for activities of daily living (ADL) and who was dependent on staff for care. Findings include: R46's significant change in condition Minimum Data Set (MDS) dated 5/2/22, identified severe cognitive impairment. R46 required an extensive assistance from two nursing staff for bed mobility,	F 677	F677 ADL Care Provided for Dependent Residents (SS=D) 1. R46 was added to bath schedule on 6/29/22 and received a bath on 7/16/22. 2. The bath schedule was reviewed on 6/29/22 to ensure all residents were included. 3. An internal transfer checklist was created on 7/21/22 to ensure continuity of care for all internal transfers. The bath task for all residents was updated to include a PRN option in addition to their	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 677	Continued From page 4 and transfers. R46 required extensive assistance from one nursing staff to accomplish her toileting, hygiene, dressing, and eating needs. R46's care plan dated 3/17/22, identified R46 required staff assistance with all ADL's. The report did not identify specific R46's bathing needs. R46's visual and bedside Kardex report dated 6/29/22, identified R46's weakness and required staff assistance to complete personal hygiene needs. The report did not identify R46's specific bathing needs. R46's last weekly skin observation report was dated 6/2/22. During the recertification survey, another skin assessment was conducted by registered nurse (RN)-B and dated 6/27/22, at 8:30 p.m. RN-B stated she realized R46's was overdue for a skin assessment and completed one for R46. No skin issues or areas of concern were identified. R46's point of care (POC) documentation dated 6/29/22, at 8:38 p.m. had no documentation for the type of bath, level of participation, and type of support provided for the past thirty days. During interview on 6/27/22, at 1:10 p.m. R46 stated she had not received a bath for a while. R46 denied refusing a bath from staff. During record review on 6/28/22, at 9:16 a.m. second floor Weekly Bath Schedule located on a bulletin board behind the nursing station had 32 residents listed for a.m. and p.m. shifts. R46's name was not on the document.	F 677	scheduled date to better document bathing activities. 4. The Director of Nursing Services and/or designee will conduct an audit of the bathing schedule daily x2 weeks, then weekly x2, then monthly x2 to ensure they reflect the care plan. Audit results will be taken to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 677	Continued From page 5 During interview on 6/28/22, 9:18 a.m. with registered nurse (RN)-B stated the Weekly Bath Schedule was not up-to-date. RN-B stated she conducted a skin assessment on 6/27/22, at 8:30 p.m. RN-B stated the assessment was not during a R46's bath time. RN-B stated she would find out why R46's name was not on the bath schedule. During interview on 6/28/22, at 9:28 a.m. nursing assistant (NA)-K stated at the start of her shift she looked at the Weekly Bath Schedule posted in the nursing station to find out which resident had a bath scheduled during her shift. During interview on 6/28/22, at 9:29 a.m. RN-A stated she referred to the Weekly Bath Schedule to find out what residents needed a skin assessment completed during their bath. RN-A stated if a resident's name was not on the schedule, the bath would be missed. RN-A verified R46 did not receive a bath in the past 30 days and would need to talk with RN-B to figure out next steps. During interview on 6/29/22, at 2:13 p.m. RN-B stated she reviewed R46's chart, and the findings indicated R46 did not receive a weekly bath and skin assessment for over 30 days. RN-B stated R46's name was now added to the bath schedule. During interview on 6/29/22, at 2:13 p.m. the director of nursing (DON) stated she expected each resident to receive a skin assessment and bath weekly. If a resident refused their bath, staff would offer at another time and document the results in a progress note. The facility policy Bathing - Rehab/Skilled dated	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 677	Continued From page 6 8/18/21, did not indicate how often a resident should receive a bath. Policy covered bathing purpose, required equipment and check list for each bathing step.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure interventions were developed and implemented to prevent falls for 2 of 3 residents (R281 and R77) who had a recent history of falls and failed to revise the care plan to prevent subsequent falls after falling at the facility. Findings include: R281's hospital Discharge Summary dated 6/20/22, indicated R281 had fallen at another facility and admitted to the hospital with a right hip fracture that was surgically repaired on 6/11/22. R281's entry tracking Minimum Data Set dated 6/20/22, indicated R281 was admitted to the facility on 6/20/22. R281's Admission Record/Face Sheet dated 6/28/22, indicated R281 had diagnoses of hip	F 689	F689 Free of Accident Hazards/Supervision/Devices (SS=D) 1. R281 and R77 no longer reside at facility. 2. All residents that experienced a fall in the last 30 days were reviewed to ensure their care plan was updated and a new intervention was implemented to prevent reoccurrence on 7/18/22. 3. The Director of Nursing and/or designee will conduct re-education on implementing interventions at time of fall by 8/5/22. Also, the interdisciplinary team conducts a comprehensive review of each fall withing the first business day. This comprehensive review includes an RCA, review of initial intervention implemented, determined if any new interventions are appropriate, and ensures documentation is complete. A falls focus meeting has been implemented. This falls focus	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 689	Continued From page 7 fracture, previous falls, and dementia. R281's Falls Tool dated 6/20/22, indicated R281 was at medium risk for falls due to previous falls, medications, diagnoses, and cognitive status. R281's care plan dated 6/20/22, indicated R281 required assist of two staff for bed mobility and transfers, and lacked a falls focus and falls interventions. A progress note dated 6/26/22, at 5:27 a.m. indicated R281 was found lying on the floor at 5:20 a.m. R281 stated she tried getting up from bed to go across the street. R281's Falls Tool dated 6/26/22, indicated R281 was at medium risk for falls due to previous falls, medications, diagnoses, and cognitive status. An incident progress note dated 6/27/22, at 6:48 p.m. indicated seven staff reviewed R281's incident and included R281 had no prior falls and identified contributing factors as dementia, surgical repair of right hip fracture, and confusion. The root cause conclusion was "Attempted self transfer/restless", and plan was to review pain medication and observe for patterns of restlessness. R281's care plan dated 6/27/22, indicated R281 lacked a falls focus and interventions to reduce risk. R281's Kardex dated 6/28/22, lacked indication of falls risk or interventions. The unit census sheet (undated, utilized by NAs to identify care needs) lacked identification of	F 689	meeting will review all incidents occurring in the past week and determine if interventions implemented have been effective, if any facility trends are found, and will update care plan as appropriate. 4. The Director of Nursing Services and/or designee will conduct an audit of resident care plans to ensure a falls focus with appropriate interventions are in place daily x2 weeks, then weekly x2, then monthly x2. Audit results will be taken to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 689	Continued From page 8 R281's fall risk. During interview on 6/26/22, at 2:57 registered nurse (RN)-G stated R281 fell the previous night because she did not know how to ask for help. She stated she was often restless, so they had her out in the common area to prevent her from falling again. She stated she came to the facility after a fall. RN-G stated she could get up from a sitting position, tried to push up with her feet while in the wheelchair, and had walked from time to time, but R281 was not consistent. During observation on 6/27/22, at 2:09 p.m. R281 was in bed covered with a sheet, angled diagonally with her head to the right edge of the bed, left foot off the left edge of the bed nearly touching the floor, and the right foot just off the edge of the left side of the bed. A unknown nurse passed by the room and did not appear to have noticed R281's positioning. R281 was observed again at 3:06 p.m. sleeping in the same position. During interview on 6/27/22, at 6:19 p.m. nursing assistant (NA)-F stated she knew who was at risk for falls by getting report from the nurses and looking at the unit census sheet but was not sure how often the sheet was updated. During observation on 6/28/22, at 8:32 a.m. R281 was observed moving from a seated position on side of bed with feet on the floor, to a lying position and with her feet up to the edge of the bed. At 8:36 a.m. R281 was sitting on the edge of the bed. At 8:44 a.m. she began grabbing at the blankets to pull them toward her. After a few minutes she leaned back and to the side, with her head on the right side of the bed and her feet on the far left.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 689	Continued From page 9 During interview on 6/28/22, at 10:34 a.m. registered nurse (RN)-F stated when a new resident was admitted staff completed the admission nursing assessment, including the fall assessment, within the first 24 hours. She stated if someone was identified as being anything other than low risk for falls upon admission, interventions were added to the care plan to reduce risk. She stated the interventions were based upon what made them at risk. She stated if a resident fell at the facility staff looked at what the resident was doing at the time to identify which interventions were appropriate and tailored them to the resident's situation. She stated the social worker, director of nursing (DON), and managers reviewed the fall details to determine if anything needed to be added to the care plan. During interview on 6/28/22, at 10:56 a.m. NA-L stated she used the unit census sheet which identified which residents were in which rooms and spelled out the care plan, including whether the resident was at risk for falls. She stated if a resident was at risk staff would make sure their bed was at the lowest level, check on them more frequently, bring them out to the dining room for meals, or, if they were too risky, they would make them sit out in the common area and provide activities for them. She stated there was nobody in the unit at risk for falls at that time, since there was nobody with mats on the floor. During observation on 6/28/22, at 11:01 a.m. social worker (SW)-A was observed walking through the common area, looked in R281's room, and stated to another staff person it appeared that R281 was going to fall. Surveyor came to room and observed R281 seated on the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 689	Continued From page 10	F 689		

edge of the foot of the bed with her right buttock on the bed and the left partially off. Additional staff entered and assisted R281 to her wheelchair.

During interview on 6/28/22, at 11:03 a.m. SW-A stated she saw R281 pivoting to her bed, and she needed assistance due to severe cognitive impairment. She stated she was trying to prevent her from falling.

R77

R77's hospital Discharge Summary dated 5/12/21, indicated R77 was hospitalized after a fall resulting in a right hip fracture on 5/6/21, which was surgically repaired on 5/7/21.

R77's Admission Record/Face Sheet dated 6/29/22, indicated R77 had diagnoses of hip fracture due to fall, cervical (neck) fracture due to fall, and respiratory failure and was admitted to the facility on 5/12/21.

R77's care plan dated 5/12/21, indicated R77 needed assist of 1 staff for transfers, and lacked a falls focus and interventions to reduce risk.

A falls incident report dated 5/15/21, at 11:30 p.m. indicated a nursing assistant answered R77's call light and found her in a seated position next to her recliner. R77 indicated she was getting up and trying to take herself to bed when her knees gave out.

R77's Falls Tool dated 5/15/21, indicated R77 was at high risk for falls due to recent falls, medications, psychological risk factors, limited mobility, and impulsive behavior. The "Update

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 689	Continued From page 11 care plan" box was not selected. A progress note dated 5/16/21, indicated R77 had a fall on the evening of 5/15/21, and R77 was reminded to use the call light. R77's care plan updated on 5/18/21, lacked a falls focus and interventions to reduce risk. During interview on 6/28/22, 11:11 a.m. licensed practical nurse (LPN)-A stated when a resident was admitted staff completed the initial nursing assessment, including the falls tool, within the first few hours after arrival to the facility. She stated if someone had a history of falls it would alert staff to ensure interventions were put in place. She stated the falls tool identified the resident fall risk and assisted in determining which interventions were appropriate top include in the care plan. She stated if a resident fell in the facility, she would try to determine what happened and why the fall occurred and add more interventions appropriate to the resident's situation. She stated all falls were reviewed by the falls committee, and they looked at the resident's medications, environment, and other factors. She stated sometimes what was in place was sufficient, and new interventions were not always necessary after a fall. During interview on 6/28/22, at 2:15 p.m. DON stated when a resident was admitted the nurse on the unit started the admission/readmission assessment, including a falls assessment, within the first 24 hours. She stated she expected every resident in the transitional care unit (TCU) was a falls risk just because of the change in environment, but anyone with risk factors	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 689	Continued From page 12 including recent falls, certain medications, impaired cognition, and/or other significant factors should have some basic intervention(s) put in place on the care plan to reduce the risk of falls as part of the baseline care plan. She stated staff, including NAs, were informed of residents' fall risk during the shift-to-shift report. DON stated if a resident fell in the facility staff completed an incident report, the resident was interviewed to determine cause, and the incident was reported to the administrator. She stated each fall was reviewed immediately to identify if staff were following the plan of care and she expected the nurse on the unit to determine the best intervention based upon the individual. She stated all fall incidents were evaluated in a team meeting the next morning to ensure added interventions were appropriate, and to determine if additional patient-centered interventions relating to the potential cause of the fall would be beneficial. DON reviewed R77's medical record and verified the baseline care plan lacked fall prevention interventions. She further verified R77's care plan lacked fall prevention interventions after the fall in the facility on 5/15/21, despite being identified as high risk. DON reviewed R281's medical record and verified R281 was at medium risk for falls upon admission and the baseline care plan lacked fall prevention interventions. She further verified R281's care plan lacked fall prevention interventions after the fall in the facility on 6/26/22. DON clarified her expectation was there should have been interventions for both R281 and R77 on their care plans upon admission, and she expected additional interventions after each fall.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 689	Continued From page 13 The facility policy Fall Prevention and Management - Rehab/Skilled, Therapy and Rehab dated 3/30/22, indicated on admission staff should complete the fall screening and identify risk factors, care plan the appropriate interventions including personalization, and communicate fall risks and interventions to prevent a fall before it occurs per the 24-hour report, care plan, Kardex, daily stand-up meeting, and/or Fall Committee meetings. Post fall, staff should complete the Falls Tool if not done in the post-fall huddle and continue to monitor the effectiveness of interventions.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 690	Continued From page 14 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a Foley catheter urine drainage bag that was kept on the floor for 1 of 2 resident (R25) reviewed for catheter care was covered. R25's quarterly Minimum Data Set (MDS) dated 4/21/22, identified R25 had severe cognitive impairment, a suprapubic Foley catheter inserted through the abdominal wall into the bladder for urinary retention. In addition, R25 had diabetes, anxiety, and depression. R25 required extensive assistance from one nursing staff for bed mobility, transfers, dressing, and toileting. R25's order summary report dated 6/18/21, identified staff were not to hang R25's Foley catheter bag from the bed frame, but to place it directly on the floor. R25's treatment record dated 5/25/21, identified staff to secure the Foley catheter to abdomen or upper thigh to prevent dislodgment. Treatment record did not include the 6/18/21, physician	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI (SS=D) 1. R25's catheter was placed in a barrier bag on 6/28/22. 2. All residents with catheters were reviewed on 7/18/22 to ensure no other catheter bags were placed on the floor or lacked an appropriate barrier. 3. The Director of Nursing Services and/or designee will conduct re-education for all nursing staff on GSS policy and procedure for catheter care by 8/5/22. 4. The Director of Nursing Services and/or designee will conduct audits of catheter care daily x2 weeks, then weekly x2, then monthly x2 to ensure care plan reflects catheter needs and catheter bags are not placed on the floor without a barrier bag in place. Audit results will be taken to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 690	Continued From page 15 order to place the drainage bag directly on the floor, nor did it identify to cover the drainage bag. R25's care plan dated 12/18/15, identified use of suprapubic catheter. Care plan did not identify placing R25's foley drainage bag on the floor, nor did it identify to cover the drainage bag. During observation on 6/27/22, at 7:30 p.m. treatment, medication assistant (TMA)-A was in R25's room. R25 was lying in bed, and TMA-A removed R25's urine drainage leg bag to connect his foley drainage bag for at night use. TMA-A placed the drainage bag directly on the floor with no cover. TMA-A stated the staff used to hook the drainage bag on R25's bed frame. TMA-a stated R25's suprapubic catheter became dislodged several times when the drainage bag was secured to the bed. TMA-A did not know the associated risk factors to R25 when his drainage bag rested on the floor. TMA-A stated, "it's a doctors order." During an interview on 6/28/22, at 12:53 p.m. registered nurse (RN)-A stated she was very surprised when she saw the physicians order to place the drainage bag on the floor. RN-A stated her number one concern was risk for developing a urinary tract infection. RN-A stated R25's provider ordered to keep the drainage bag on the floor related to R25 restless movements while lying in bed, leading to the suprapubic catheter being dislodged During interview on 6/29/22, at 7:32 a.m. RN-B stated the practice to place R25's foley drainage bag on the floor was not a best practice, but the risk of R25 pulling out his suprapubic catheter outweighed the risk for infection. RN-B stated	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 690	Continued From page 16 R25 would get up to use the bathroom in the middle of the night consequently pulling out his suprapubic catheter. In addition to pulling on the suprapubic catheter multiple times caused an irritation at the insertion site. The site irritation required antibiotic therapy to heal. RN-B stated, "we all know placing the drainage bag on the floor is not the thing to do." RN-B ordered a "dignity" bag to place the drainage bag into, consequently providing a limited exposure to the floor. During interview on 6/29/22, at 7:43 a.m. the director of nursing (DON) agreed placing a foley drainage bag on the floor was an infection risk, DON stated the staff have placed a barrier bag over the drainage bag to limit the direct exposure to the floor. Facility policy Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen - Assisted Living, Rehab/Skilled dated 4/25/22, identified catheter bags were to be covered up when a resident sat in a chair. The policy did not identify preventing the drainage bag from touching the floor. The policy identified staff to place a barrier between the floor and the drainage bag when draining out the urine.	F 690		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 744	F744 Treatment/Service for Dementia	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 744	Continued From page 17 review, the facility failed to comprehensively assess and implement individualized person centered dementia care for 1 of 2 residents (R3) reviewed for dementia care. Findings include: R3's admission record dated 6/6/29/22, indicated R3 admitted on 11/5/20, with diagnosis of dementia with Lewy bodies, post-traumatic stress disorder (PTSD), panic disorder, hallucinations, and unspecified psychosis. R3's annual Minimum Data Set (MDS) dated 6/9/22, indicated R3 was severely cognitively impaired with physical behaviors, verbal behaviors, other behavioral symptoms directed towards others, rejection of care, and wandering which R3 received antipsychotic and antianxiety medications. Further, indicated R3 enjoys listening to music, being around animals, keeping up with the news, and spending time outdoors. The MDS lacked evidence of restraint usage. R3's care plan dated 7/15/21, indicated R3 had a behavior symptom related to Lewy body dementia and PTSD as evidenced by pacing, psychosis, paranoid personality disorder, chronic hallucinations, delusional thinking, wandering, hoarding of food, pacing at night, rejection of cares, intrusive or disruptive to others when upset, and wanders into peer rooms at times with interventions to intervene as necessary to protect the rights and safety of others, provide opportunity for positive interaction, discuss behavior and explain why behavior is inappropriate and/or unacceptable. The care plan lacked any evidence of individualized person-centered interventions for behaviors.	F 744	(SS=D) 1. Associated Clinic of Psychology visit with R3 scheduled for 7/21/22 to explore alternative interventions for behavior management. 2. All residents with a dementia diagnosis with behavioral symptoms reviewed to ensure person-centered interventions were included on 7/18/22. 3. The Director of Nursing and/or designee will conduct re-education for all staff caring for residents with dementia on GSS policy and procedure for person centered care for residents with dementia by 8/5/22. 4. The Director of Social Services and/or designee will conduct audits of care plans daily x2 weeks, then weekly x2, then monthly x2 to ensure interventions are in place for person centered dementia care. Audit results will be taken to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 744	Continued From page 18 R3's order summary report dated 6/29/22, indicated a physician order to utilize a Broda chair with thigh latching belt in chair as needed during episodes of increased mental distress, anxiousness, and physical ability decline. The order summary report lacked any evidence of interventions to utilize prior to placing R3 into the Broda chair with the restraint. R3's kardex dated 6/29/22, lacked any evidence of individualized person-centered interventions for behaviors. R3's progress note dated 6/27/22, at 10:30 a.m. indicated R3 was in the Broda chair and continued to be anxious with hallucinations. The progress note lacked any evidence of individualized person-centered interventions to lessen R3's anxiousness and hallucinations. R3's progress note dated 6/25/22, at 10:11 p.m. indicated R3 was agitated early afternoon and staff placed R3 in the Broda chair with back latching thigh restraint. The progress note lacked any evidence of individualized person-centered interventions to lessen R3's agitation prior to placing R3 into a restraint. R3's regulatory visit note dated 6/7/22, indicated facility staff were to utilize nonpharmacological interventions and maintain a structured environment for R3's continued behaviors. R3's Associated Clinic of Psychology (ACP) note dated 8/19/21, indicated the treatment plan continued until 7/2022. The treatment plan recommended R3 would benefit from increased one-on-one activities to increase his socialization	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 744	Continued From page 19 and build a routine, watching television shows about cars, meeting with peers who have the same interests and cognitive abilities, time outside, and chaplain visits. R3's care plan lacked any evidence of the recommendations. During observation on 6/27/22, at 2:15 p.m. R3 was in the Broda chair with back latching thigh strap restraint in place. R3 wandered into another resident room when nursing assistant (NA)-F walked up to R3's Broda chair and started pulling the Broda chair backwards without explaining to R3 what was happening. R3 placed his feet on the floor and resisted the Broda chair being removed from the doorway of the other resident's room. NA-O walked up to assist NA-F and picked up R3's feet while NA-F pulled the Broda chair backwards again while stating, "you need to go to your room" repeatedly. R3 grabbed the wall resisting and stopping the staff from pulling the chair backwards. NA-F shut the door to the other resident's room and continued to attempt to pull the Broda chair backwards. NA-F stated to R3, "which way do you want to go" when R3 stated, "whichever way you want me to go to please you". NA-F then stated to R3, "you're not pleasing me". At this time, both NA-F and NA-O stood in front of R3's Broda chair blocking him from moving the chair. NA-F also placed her left foot in front of the wheel on the Broda chair blocking R3 from moving the chair. R3 eventually left the area. During observation on 6/27/22, at 6:59 p.m. R3 was in the Broda chair with the back latching thigh strap restraint when NA-G walked up and asked R3 if he wanted to go to his room to go to bed. R3 stated, "no". NA-G started pushing the Broda chair forward while R3 placed both feet on	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 744	Continued From page 20	F 744		

the floor attempting to resist being moved. NA-G continued to push the Broda chair despite R3 resisting. NA-G stated throughout this process, "you need to go to bed" repeatedly.

Upon interview on 6/27/22, at 7:47 p.m. NA-F stated R3 is placed in the Broda chair with the restraint when he has behaviors such as wandering into other resident's rooms. NA-F unable to explain any interventions to utilize for R3's behaviors beside the Broda chair and restraint. NA-F further stated, when R3 "plants his feet and we push him out of a room or to his room anyway I don't consider that forcing him because he doesn't know what he is doing so we do what we think is best for him".

Upon interview on 6/28/22, at 10:37 a.m. NA-P stated when R3 has behaviors of wandering the staff place him in his Broda chair with the restraint. NA-P unable to voice other interventions to relieve R3's behaviors.

Upon interview on 6/28/22, at 10:40 a.m. NA-Q stated when R3 wanders into other resident's rooms we place him in his Broda chair with the restraint. NA-Q unable to voice other interventions to relieve R3's behaviors.

Upon interview on 6/28/22, at 10:50 a.m. registered nurse (RN)-D stated the staff should use the Broda chair with the restraint as the last resort. However, stated when R3 becomes delusional it affects R3's physical state as well and the staff will place R3 in the Broda chair with the restraint to keep R3 safe.

Upon interview on 6/28/22, at 11:36 a.m. the director of nursing (DON) stated the staff should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 744	Continued From page 21 attempt interactions or other interventions prior to placing R3 in the Broda chair with the restraint. DON verified the staff should have utilized other interventions instead of attempting to move R3 while he was resisting. DON further verified the care plan did not have individualized person-centered interventions for R3's behaviors. Upon interview on 6/29/22, at 12:40 p.m. the DON verified NA-F and NA-G had not completed the annual required dementia training. The dementia care guidelines policy dated 2/17/22, indicated staff are to remain calm and not respond inappropriately to the behavior, never use physical force, avoid the use of physical restraints, and attempt to de-escalate an aggressive behavior verbally. Further, indicated to utilize individualized, non-pharmacological approaches for behaviors. The behavioral causes and interventions policy dated 9/24/21, indicated strategies for addressing aggressive behaviors are as follows: 1. Approach resident in a calm, non-threatening manner 2. Maintain eye contact and place yourself at the same level as the resident. Do not touch the resident; this may be perceived as threatening and could cause him or her to strike out. 3. Speak in a calm tone of voice. 4. Allow enough physical space between you and the resident so the resident does not feel threatened. 5. If the resident becomes aggressive while providing care, off to return later. 6. If a resident is displaying aggressive behaviors, consider leaving the resident in a safe place and returning after a short period.	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 744	Continued From page 22 7. Provide consistency with care and routine as often as possible.	F 744		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently monitor dish machine temperatures to ensure proper sanitation of dishware to prevent the potential for food-borne illness which could affect 86 of 87 residents who received meals prepared and served by the facility. Findings include: During interview on 6/29/22, at 7:21 a.m. dietary aide (DA)-A stated after she arrived at work, she	F 812	F812 Food Procurement, Store/Prepare/Serve Sanitary (SS=F) 1. Dishwasher temperatures were reviewed upon notification. 2. This citation has the potential to affect all residents. 3. The Dietary Manager and/or designee will conduct re-education for all staff responsible for dishwashing on proper use of the dishwashing machines and logging temperatures appropriately on 7/29/22.	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 812	Continued From page 23 turned on the dishwasher to let it warm up, put a load of cups in the dishwasher, and ran the load. She stated she usually waited until the second load to document dishwasher temperatures which should read at least 150 degrees Fahrenheit (°F) during the wash cycle and 180°F during the rinse cycle. During observation of the washing of the second load of dishes for the morning the wash temperature was 152°F and the rinse temperatures was 179°F. She stated the dishes were clean even if the temperature was not up to 180°F because it was still hot, and she could see the steam which forced her to remove her eye protection to see. She stated if she saw visible food left on dishes after washing, she placed the soiled dish into the sink to soak. During a second observation the wash temperature reached 151°F and the rinse temperature was 177°F. DA-A record these results on the Dish Machine Temperature Log. During interview on 6/29/22, at 7:55 a.m. DA-B. stated dishwasher temperatures should reach 150°F during the wash cycle and 180°F during the rinse cycle. She stated she ran a load of about five glasses and some silverware earlier that morning, but temperatures were only required to be documented three times per day after each meal. She stated if she remembered to do it, she recorded temperatures 'at some point' after a load of dishes was done after breakfast, sometimes with the first load. The Dish Machine Temperature Log - Thermal Sanitizing form indicated the final rinse temperature should be 180°F, and wash temperature should be based on federal, state, and manufacturer's guidelines, whichever is most strict. The Dish Machine Temperature Logs dated	F 812	4. The Dietary Manager and/or designee will conduct audits of dishwasher temperatures daily x2 weeks, then weekly x2, then monthly x2 to ensure temperatures are recorded accurately. Audit results will be taken to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 812	Continued From page 24 6/2022, for the six resident kitchenettes lacked recorded dishwasher wash and rinse cycle temperatures for 216 of 504 meals (42.8%) between 6/1/22, and 6/28/22. The logs also identified final rinse temperatures below 180°F for 38 of 504 meals (7.5%) during the same period. During interview on 6/29/22, at 8:07 a.m. with registered dietician (RD) and dietary manager (DM), DM stated the DA on each floor washed the dishes after each meal. He stated he believed the wash temperatures for the high-temperature dishwashers should be 160°F and the rinse temperature should be 180°F and expected temperatures to be documented three times per day after each meal, at any time during any of those runs. RD agreed it did not matter during which load the dishwasher temperatures were recorded. DM stated he did not know how he would identify if the loads prior to the recording were sanitized, but it was important to ensure dishes were clean to prevent food-borne illness. During interview on 6/29/22, at 10:05 a.m. administrator stated she expected dishwasher temperatures to have been taken as required, and if staff noted a concern, they should alert the supervisor who could take action. She stated she was not familiar with the details of the dishwashing process but indicated staff would not know if dishes washed before temperatures were taken were properly sanitized, which could result in unclean dishes and potential for food-borne illness. The LXi Series Dishwasher Instructions dated 9/2010, indicated wash temperature should be above 150°F. The dish machine is identified as having a built-in 70°F booster heater and requires	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 812	Continued From page 25 an incoming water temperature of 110°F to reach the proper rinse temperature (180°F). The Hobart LXi Series label affixed to the dish machines indicated the wash temperature must reach a minimum of 150°F and rinse temperature must reach 180°F for hot water sanitizing. The Warewashing-Mechanical and Manual - Food and Nutrition policy dated 4/26/22, indicated each location is to compare federal regulations, state regulations, and manufacturer's guidelines and write appropriate temperatures on the Dish Machine Temperature Log, and must follow the strictest guideline. The policy identified staff were to check compliance for wash and rinse cycles each meal service and record the temperature on the log.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 880	Continued From page 26 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 880	Continued From page 27 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, review of the facility policy, and review of Centers for Disease Control and Prevention (CDC) guidance, the facility failed to ensure appropriate personal protective equipment (PPE) was implemented for 2 of 2 residents (R230, R233) who were under quarantine, new admissions, and were not fully vaccinated. Findings include: Review of CDC guidance, dated 02/22/22, indicated ". . . HCP [Health Care Professional] caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator) ...". Review of the CDC guidance, dated 05/24/22, ". . .You are up to date with your COVID-19 vaccines when you have received all doses in the primary series and all boosters recommended for you, when eligible. Vaccine recommendations are different depending on your age, the vaccine you first received, and time since last dose, as shown below. R230's nursing progress note dated 6/24/22, at	F 880	F880 Infection Prevention & Control (SS=D) 1. R230 no longer resides at facility. R233 completed her isolation period and was removed from transmission-based precautions on 7/8/22. 2. All residents admitted within the last 10 days that are not up to date with their COVID-19 vaccinations reviewed to ensure they are placed on isolation precautions (gray zone) on 7/19/22. 3. A root cause analysis (RCA) was conducted on 7/14/22 in accordance with the dPOC. As a result, new signage printed and posted on the doors of residents on transmission-based precautions to reflect the proper PPE required on 7/15/22. The Director of Nursing and/or designee will conduct re-education for all staff caring for residents on transmission-based precautions on appropriate PPE use and donning/doffing PPE by 8/5/22. 4. The Director of Nursing and/or designee will conduct observation audits of staff PPE use and donning/doffing PPE daily x2 weeks, then weekly x2, then monthly x2 to ensure PPE is used in accorded with CDC guidelines. Audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 880	Continued From page 28 11:39 p.m. indicated R230 was on 10-day isolation due to being unvaccinated for COVID-19. During an observation on 6/26/22, at 9:08 a.m. R2's door was closed with a sign on the outside that read "Gray Zone" with dates 6/20-6/30 written on. The sign further indicated PPE requirement was a gown, face shield, gloves were required to enter. The sign further indicated a N-95 was preferred but was required for aerosol generating procedures. During an observation on 6/26/22, at 1:35 p.m. nursing assistant (NA)-C entered R230's room. NA-C had a surgical mask on, eye goggles, and a gown. NA-C had not donned gloves. NA-C entered R230's room and was in the room for approximately 1 minute. NA-C exited with gown in place. Set NA-C's lunch tray on the cart outside the room. NA-C was observed to still not have gloves donned. NA-C removed the gown and placed it into a laundry hamper outside of R230's room. Without performing hand hygiene, NA-C pushed the cart over towards the nurse's desk. Stopped to obtain hand sanitizer before again pushing the cart over to the kitchenette. An interview on 6/26/22, at 1:47 p.m. NA-C stated R230 was not vaccinated for COVID-19 and was on isolation. NA-C stated a N-95 mask was not required and a surgical mask was acceptable. NA-C further stated they forgot to put gloves on when entering the room and acknowledged gloves were required when entering R230's room. An interview on 6/27/22, at 6:12 p.m. NA-A stated gray zone signs were placed for residents who do not have their vaccination or booster for	F 880	results will be taken to the QAPI committee for further recommendations. dPOC submitted as attachments on 7/28 Document 1. Root cause analysis, five whys, and fishbone. Document 2. Audits (two attachments) Document 3. Education content and summary. Document 4. Sign in sheet for education sessions and training meetings. Education is scheduled via online service center and continues per 8/5/22 completion date. Document 5. Blank test. Education continues per 8/5/22 completion date.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 880	Continued From page 29	F 880		

COVID-19. NA-A further stated gown, gloves, mask and goggles were needed to enter the room and a N-95 mask was not required.

R233's progress note dated 6/28/22, at 9:46 p.m. indicated R233 was admitted with a leg fracture and was alert and
orientated to person, place, and time.

During an observation on 6/27/22, at 6:09 p.m. R233's door was closed with a sign on the outside that read "Gray Zone" with dates 6/27-7/7 written on. The sign further indicated PPE requirement was a gown, face shield, gloves were required to enter. The sign further indicated a N-95 was preferred but was required for aerosol generating procedures.

During an observation on 6/29/22, at 10:33 a.m. NA-B was observed exiting R233's room only wearing a surgical mask and face shield.

An interview on 6/29/22, at 10:34 a.m. NA-B stated R233 was on isolation for COVID-19 as R233 hasn't taken a COVID-19 test and was not sure about R233's vaccination status. NA-B stated a regular mask could be worn and a N95 was not required. Furthermore, gloves were required only for cares that required them. NA-B stated a gown was needed and acknowledged he had not used one as NA-B was "only going to be in the room for a short period of time" just to help R233 to the bathroom and didn't want R233 to have an accident.

An interview on 6/29/22, at 10:40 a.m. licensed practical nurse (LPN)-A verified R233 had not received any boosters and was over the age of 50 and therefore was not current with the COVID-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 880	Continued From page 30 vaccinations. LPN-A verified a gown, goggles, mask, and gloves were needed to enter R233's room. LPN-A further stated a N95 should be used and stated there was not a shortage of PPE at the building. An interview on 6/29/22, at 11:45 a.m. registered nurse (RN)-C stated the expectation was for staff to don gown, gloves, eye protection and a mask when entering gray zone rooms. RN-C stated if there was an AGP or if staff felt better wearing one, they could. RN-C was not sure what the CDC guidelines were for PPE and further stated since starting at the facility, the signs always indicated a N95 was not a requirement for residents in quarantine for COVID-19. An interview on 6/29/22, at 10:01 p.m. the Director of Nursing (DON) stated staff are required to wear an N-95 mask, gown, gloves and eye protection when entering a resident who was COVID-19 positive or an unvaccinated resident who was new to the facility on quarantine. A facility policy titled Personal Protective Equipment revised 5/26/21. directed the facility was responsible to ensure staff utilized appropriate PPE when caring for residents.	F 880		
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:	F 886		8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 31 §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 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	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 32 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 facility failed to test staff for COVID-19 according to Centers for Medicare and Medicaid (CMS) guidance for routine testing requirements. This deficient practice had the potential to affect all 87 residents residing in the facility, all staff, and any visitors to the facility. Findings include: The CMS QSO-20-38-Nursing Home memo revised 3/10/22, directed all facilities located within a high or substantial county community transmission level to conduct twice weekly routine COVID-19 testing for all staff who were not up-to-date with the required COVID-19 vaccinations... "Up-to-Date" means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible. The facility should test all staff, who are not up-to-date, at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past	F 886	F886 COVID-19 Testing-Residents & Staff (SS=F) 1. A new testing process was implemented on 7/20/22. Rather than testing before working, there are now scheduled testing dates/times that employees must utilize or schedule an appointment for. At the end of testing days, employees that fail to test will be removed from the schedule. 2. This citation has the potential to affect all residents. 3. A tracking system has been developed to ensure all staff not up to date with their vaccinations are tested per CDC guidelines. 4. The Administrator and/or designee will review this tracking system daily x2 weeks, then weekly x2, then monthly x2 to ensure employees are not working without completing the required testing. Audit results will be taken to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 33 week and facilities should use their community transmission level as the trigger for staff testing frequency. County positivity rate for facility county reported high on: 4/20/22, high. 4/27/22, high. 5/5/22, high. 5/10/22, high. 6/3/22, high. 6/7/22, high. 6/15/22, high. 6/22/22, high. During record review on 6/28/22, identified five current employees who did not receive the COVID-19 vaccination related to an approved exemption. COVID-19 testing for the five employees includes: 1. New employee RN-E worked six times between 6/14/22, through 6/28/22. Facility lacked evidence of COVID- 19 testing during these two-week periods. 2. Dietary aid (DA)-A worked seven times between 6/14/22, through 6/28/22. During the two-week timeframe DA-A received one COVID-19 test, instead of the required four. 3. NA-M worked 25 times between 4/28/22, through 6/22/22. During the six-week time frame NA-M received three COVID-19 tests, instead of the required 12. 4. RN-H worked 24 times between 4/28/22, through 6/22/22. During the seven-week, time frame RN-H received one COVID-19 test, instead of the required 14. During record review on 6/28/22, requested a sample of ten staff who did not receive a	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 34 COVID-19 booster vaccination. One employee no longer worked at the facility. Another employee was a contract nursing agency staff who received testing from her employee. Two employees had received a COVID-19 booster at the facility but had not been updated on the spreadsheet. COVID-19 testing for the remaining six staff include: 1. NA-C worked five days between 4/28/22, through 5/5/22. NA-C completed one test on 5/4/22, instead of the required two. 2. DA-C worked five days between 4/28/22, through 5/5/22. In addition, DA-C worked four days between 6/20/22, and 6/28/22. Facility lacked evidence of COVID 19 testing during these two-week periods. 3. DA-D worked six days between 4/28/22, through 5/5/22. In addition, DA-D worked four days 6/11/22, through 6/28/22. During the three-week time frame DA-D received one COVID-19 test, instead of the required six. 4. NA-J worked 12 days between 5/15/22, through 6/28/22. Facility lacked evidence of COVID-19 testing during these five-week periods. 5. NA-N had an alternative schedule working every other weekend. NA-N worked seven days between 5/6/22, through 6/19/22. Facility lacked evidence of COVID-19 testing during these five-week periods. 6. NA-H worked 12 times between 4/28/22, thorough 6/10/22, and four times between 6/20/22, through 6/28/22. During the six-week time frame NA-H received one COVID-19 test, instead of the required 22. During interview on 6/28/22, at 1:45 p.m. nursing assistant (NA)-E stated she completed her primary COVID-19 vaccination but had not received a COVID-19 booster. NA-E was unsure	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 35 the last time she completed a COVID-19 test. NA-E was unsure the number of times per week testing was required. During interview on 6/29/22, 10:05 a.m. RN-I, who was the infection preventionist, and Director of nursing (DON) stated the facility did not conduct scheduled bi-weekly COVID-19 testing. DON stated the employees were not required to get a test on their day off. Floor nursing managers were responsible to conduct a COVID-19 test for their employees two times a week during their working hours. DON added the facility stopped mandatory set days for COVID-19 testing over a year ago. During interview on 6/29/22, at 1:50 p.m. RN-C stated the administrator emails the nursing managers a list of the employees who require COVID-19 testing twice a week. RN-C stated she will cross-reference the employees with their work schedule. RN-C was responsible for 12 employees bi-weekly COVID-19 testing. RN-C added, she provided the employee with the test, and the documentation required for taking the test. RN-C sends the completed documentation to the administration office. RN-C reviewed the testing dates for the un-vaccinated staff. RN-C identified NA-J stated she received a booster, but no documentation was provided, therefore RN-C will continue to test until NA-J brings in her documentation. RN-C stated she was responsible for conducting NA-N's bi-weekly COVID-19 test. RN-C added NA-N only worked every other weekend and it was hard to test him bi-weekly. During interview on 6/29/22, at 2:04 p.m. RN-D stated he cross referenced the list of	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(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 36 un-vaccinated employees who required a bi-weekly COVID-19 test with the unit schedule. RN-D added some employees test on Tuesday and Thursday, others test on a different day based on when they are scheduled to work. During interview on 6/29/22, at 2:32 p.m. RN-I stated she was responsible for importing staff COVID-19 test results into National Healthcare Safety Network (NHSN). RN-I stated bi-weekly COVID-19 testing was mandatory for all employees (full time, part time and on call) who are not vaccinated or did not receive a COVID-19 booster. Staff are not expected to get a test on their days off but to work with their managers to accomplish the task. RN-I stated she had not seen NA-N or DA-D on the schedule for a long time. RN-I added the facility currently employed 134 personnel. NHSN report dated 6/12/22, indicated 85.9 percent of their employees completed a COVID-19 primary vaccination, and 50.6 percent of their employees received a COVID-19 booster vaccination. RN-I stated she did not think the facility tested 66 staff bi-weekly. Facility policy COVID-19 Employee Screening, Testing, reporting, and Return to Work Enterprise dated, 7/6/21, identified employee testing for COVID-19 would be conducted based on the Center for Disease Control (CDC). CMS guidelines would be used for routine testing at no cost to the employee. Policy referenced Sanford Employee COVID-19 Work and Testing Guidelines for additional instructions, but policy was not provided for review.	F 886		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 19, 2022

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

Re: Reinspection Results
Event ID: 9Q2112

Dear Administrator:

On August 12, 2022 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 June 29, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
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
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/26/22 through 6/29/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 0302, 0830, 0835, 1015 and 1565.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5279116C (MN73021), with a licensing order issued at 0830. The following complaints were found to be UNSUBSTANTIATED: H5279117C (MN78949). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with	2 302		8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 3 this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 (nursing assistant (NA)-E, NA-F, NA-G) of the facility's direct care staff received the required Alzheimer's disease or related disorder training. This had the potential to affect all 43 residents with dementia residing in the facility. Findings include: Review of the facility information provided from the CMS 672 Federal form indicated the facility had 43 residents diagnosed with dementia residing in the facility at the time of recertification survey. A facility document Completion Report Activity, dated 6/28/22, lacked evidence NA-E, NA-F, and NA-G had completed the facility's dementia training for 2021. During an interview on 6/29/22, at 12:40 p.m. the director of nursing (DON) verified staff not on the completion list had not completed the dementia training. The education was a part of staff annual training, and the expectation was for it to be completed, but staff were in "catch up mode". A facility policy titled Competency and Mandatory Education Requirements revised 10/15/2019, directed the facility required organizational mandatory education to maintain and improve competency.	2 302	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 302	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review and revise current policies and procedures on dementia training for employees to ensure timely training is accomplished. The administrator, director of nursing or designee could perform audits on annual dementia training to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure interventions were developed and implemented to prevent falls for 2 of 3 residents (R281 and R77) who had a recent history of falls and failed to revise the care plan to prevent subsequent falls after falling at the facility.	2 830	Corrected.	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 Findings include: R281's hospital Discharge Summary dated 6/20/22, indicated R281 had fallen at another facility and admitted to the hospital with a right hip fracture that was surgically repaired on 6/11/22. R281's entry tracking Minimum Data Set dated 6/20/22, indicated R281 was admitted to the facility on 6/20/22. R281's Admission Record/Face Sheet dated 6/28/22, indicated R281 had diagnoses of hip fracture, previous falls, and dementia. R281's Falls Tool dated 6/20/22, indicated R281 was at medium risk for falls due to previous falls, medications, diagnoses, and cognitive status. R281's care plan dated 6/20/22, indicated R281 required assist of two staff for bed mobility and transfers, and lacked a falls focus and falls interventions. A progress note dated 6/26/22, at 5:27 a.m. indicated R281 was found lying on the floor at 5:20 a.m. R281 stated she tried getting up from bed to go across the street. R281's Falls Tool dated 6/26/22, indicated R281 was at medium risk for falls due to previous falls, medications, diagnoses, and cognitive status. An incident progress note dated 6/27/22, at 6:48 p.m. indicated seven staff reviewed R281's incident and included R281 had no prior falls and identified contributing factors as dementia, surgical repair of right hip fracture, and confusion. The root cause conclusion was "Attempted self	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 transfer/restless", and plan was to review pain medication and observe for patterns of restlessness. R281's care plan dated 6/27/22, indicated R281 lacked a falls focus and interventions to reduce risk. R281's Kardex dated 6/28/22, lacked indication of falls risk or interventions. The unit census sheet (undated, utilized by NAs to identify care needs) lacked identification of R281's fall risk. During interview on 6/26/22, at 2:57 registered nurse (RN)-G stated R281 fell the previous night because she did not know how to ask for help. She stated she was often restless, so they had her out in the common area to prevent her from falling again. She stated she came to the facility after a fall. RN-G stated she could get up from a sitting position, tried to push up with her feet while in the wheelchair, and had walked from time to time, but R281 was not consistent. During observation on 6/27/22, at 2:09 p.m. R281 was in bed covered with a sheet, angled diagonally with her head to the right edge of the bed, left foot off the left edge of the bed nearly touching the floor, and the right foot just off the edge of the left side of the bed. A unknown nurse passed by the room and did not appear to have noticed R281's positioning. R281 was observed again at 3:06 p.m. sleeping in the same position. During interview on 6/27/22, at 6:19 p.m. nursing assistant (NA)-F stated she knew who was at risk for falls by getting report from the nurses and looking at the unit census sheet but was not sure	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 how often the sheet was updated. During observation on 6/28/22, at 8:32 a.m. R281 was observed moving from a seated position on side of bed with feet on the floor, to a lying position and with her feet up to the edge of the bed. At 8:36 a.m. R281 was sitting on the edge of the bed. At 8:44 a.m. she began grabbing at the blankets to pull them toward her. After a few minutes she leaned back and to the side, with her head on the right side of the bed and her feet on the far left. During interview on 6/28/22, at 10:34 a.m. registered nurse (RN)-F stated when a new resident was admitted staff completed the admission nursing assessment, including the fall assessment, within the first 24 hours. She stated if someone was identified as being anything other than low risk for falls upon admission, interventions were added to the care plan to reduce risk. She stated the interventions were based upon what made them at risk. She stated if a resident fell at the facility staff looked at what the resident was doing at the time to identify which interventions were appropriate and tailored them to the resident's situation. She stated the social worker, director of nursing (DON), and managers reviewed the fall details to determine if anything needed to be added to the care plan. During interview on 6/28/22, at 10:56 a.m. NA-L stated she used the unit census sheet which identified which residents were in which rooms and spelled out the care plan, including whether the resident was at risk for falls. She stated if a resident was at risk staff would make sure their bed was at the lowest level, check on them more frequently, bring them out to the dining room for meals, or, if they were too risky, they would make	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 them sit out in the common area and provide activities for them. She stated there was nobody in the unit at risk for falls at that time, since there was nobody with mats on the floor. During observation on 6/28/22, at 11:01 a.m. social worker (SW)-A was observed walking through the common area, looked in R281's room, and stated to another staff person it appeared that R281 was going to fall. Surveyor came to room and observed R281 seated on the edge of the foot of the bed with her right buttock on the bed and the left partially off. Additional staff entered and assisted R281 to her wheelchair. During interview on 6/28/22, at 11:03 a.m. SW-A stated she saw R281 pivoting to her bed, and she needed assistance due to severe cognitive impairment. She stated she was trying to prevent her from falling. R77 R77's hospital Discharge Summary dated 5/12/21, indicated R77 was hospitalized after a fall resulting in a right hip fracture on 5/6/21, which was surgically repaired on 5/7/21. R77's Admission Record/Face Sheet dated 6/29/22, indicated R77 had diagnoses of hip fracture due to fall, cervical (neck) fracture due to fall, and respiratory failure and was admitted to the facility on 5/12/21. R77's care plan dated 5/12/21, indicated R77 needed assist of 1 staff for transfers, and lacked a falls focus and interventions to reduce risk. A falls incident report dated 5/15/21, at 11:30 p.m.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 indicated a nursing assistant answered R77's call light and found her in a seated position next to her recliner. R77 indicated she was getting up and trying to take herself to bed when her knees gave out. R77's Falls Tool dated 5/15/21, indicated R77 was at high risk for falls due to recent falls, medications, psychological risk factors, limited mobility, and impulsive behavior. The "Update care plan" box was not selected. A progress note dated 5/16/21, indicated R77 had a fall on the evening of 5/15/21, and R77 was reminded to use the call light. R77's care plan updated on 5/18/21, lacked a falls focus and interventions to reduce risk. During interview on 6/28/22, 11:11 a.m. licensed practical nurse (LPN)-A stated when a resident was admitted staff completed the initial nursing assessment, including the falls tool, within the first few hours after arrival to the facility. She stated if someone had a history of falls it would alert staff to ensure interventions were put in place. She stated the falls tool identified the resident fall risk and assisted in determining which interventions were appropriate top include in the care plan. She stated if a resident fell in the facility, she would try to determine what happened and why the fall occurred and add more interventions appropriate to the resident's situation. She stated all falls were reviewed by the falls committee, and they looked at the resident's medications, environment, and other factors. She stated sometimes what was in place was sufficient, and new interventions were not always necessary after a fall.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 During interview on 6/28/22, at 2:15 p.m. DON stated when a resident was admitted the nurse on the unit started the admission/readmission assessment, including a falls assessment, within the first 24 hours. She stated she expected every resident in the transitional care unit (TCU) was a falls risk just because of the change in environment, but anyone with risk factors including recent falls, certain medications, impaired cognition, and/or other significant factors should have some basic intervention(s) put in place on the care plan to reduce the risk of falls as part of the baseline care plan. She stated staff, including NAs, were informed of residents' fall risk during the shift-to-shift report. DON stated if a resident fell in the facility staff completed an incident report, the resident was interviewed to determine cause, and the incident was reported to the administrator. She stated each fall was reviewed immediately to identify if staff were following the plan of care and she expected the nurse on the unit to determine the best intervention based upon the individual. She stated all fall incidents were evaluated in a team meeting the next morning to ensure added interventions were appropriate, and to determine if additional patient-centered interventions relating to the potential cause of the fall would be beneficial. DON reviewed R77's medical record and verified the baseline care plan lacked fall prevention interventions. She further verified R77's care plan lacked fall prevention interventions after the fall in the facility on 5/15/21, despite being identified as high risk. DON reviewed R281's medical record and verified R281 was at medium risk for falls upon admission and the baseline	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 care plan lacked fall prevention interventions. She further verified R281's care plan lacked fall prevention interventions after the fall in the facility on 6/26/22. DON clarified her expectation was there should have been interventions for both R281 and R77 on their care plans upon admission, and she expected additional interventions after each fall. The facility policy Fall Prevention and Management - Rehab/Skilled, Therapy and Rehab dated 3/30/22, indicated on admission staff should complete the fall screening and identify risk factors, care plan the appropriate interventions including personalization, and communicate fall risks and interventions to prevent a fall before it occurs per the 24-hour report, care plan, Kardex, daily stand-up meeting, and/or Fall Committee meetings. Post fall, staff should complete the Falls Tool if not done in the post-fall huddle and continue to monitor the effectiveness of interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls to assure proper assessment and interventions are being implemented, then re-educate staff on the policies and procedures. The DON or designess could develop system for evaluating and monitoring consistent implementation of these policies, and tyhe audit results could be reviewed at the facility's Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 12	21015		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently monitor dish machine temperatures to ensure proper sanitation of dishware to prevent the potential for food-borne illness which could affect 86 of 87 residents who received meals prepared and served by the facility. Findings include: During interview on 6/29/22, at 7:21 a.m. dietary aide (DA)-A stated after she arrived at work, she turned on the dishwasher to let it warm up, put a load of cups in the dishwasher, and ran the load. She stated she usually waited until the second load to document dishwasher temperatures which should read at least 150 degrees Fahrenheit (°F) during the wash cycle and 180°F during the rinse cycle. During observation of the washing of the second load of dishes for the morning the wash temperature was 152°F and the rinse temperatures was 179°F. She stated the dishes were clean even if the temperature was not up to 180°F because it was still hot, and she could see the steam which forced her to remove her eye protection to see. She stated if she saw visible food left on dishes after washing, she placed the soiled dish into the sink to soak. During a second observation the wash temperature reached 151°F	21015	Corrected.	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 13 and the rinse temperature was 177°F. DA-A record these results on the Dish Machine Temperature Log. During interview on 6/29/22, at 7:55 a.m. DA-B. stated dishwasher temperatures should reach 150°F during the wash cycle and 180°F during the rinse cycle. She stated she ran a load of about five glasses and some silverware earlier that morning, but temperatures were only required to be documented three times per day after each meal. She stated if she remembered to do it, she recorded temperatures 'at some point' after a load of dishes was done after breakfast, sometimes with the first load. The Dish Machine Temperature Log - Thermal Sanitizing form indicated the final rinse temperature should be 180°F, and wash temperature should be based on federal, state, and manufacturer's guidelines, whichever is most strict. The Dish Machine Temperature Logs dated 6/2022, for the six resident kitchenettes lacked recorded dishwasher wash and rinse cycle temperatures for 216 of 504 meals (42.8%) between 6/1/22, and 6/28/22. The logs also identified final rinse temperatures below 180°F for 38 of 504 meals (7.5%) during the same period. During interview on 6/29/22, at 8:07 a.m. with registered dietician (RD) and dietary manager (DM), DM stated the DA on each floor washed the dishes after each meal. He stated he believed the wash temperatures for the high-temperature dishwashers should be 160°F and the rinse temperature should be 180°F and expected temperatures to be documented three times per day after each meal, at any time during any of those runs. RD agreed it did not matter during which load the dishwasher temperatures were	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 14 recorded. DM stated he did not know how he would identify if the loads prior to the recording were sanitized, but it was important to ensure dishes were clean to prevent food-borne illness. During interview on 6/29/22, at 10:05 a.m. administrator stated she expected dishwasher temperatures to have been taken as required, and if staff noted a concern, they should alert the supervisor who could take action. She stated she was not familiar with the details of the dishwashing process but indicated staff would not know if dishes washed before temperatures were taken were properly sanitized, which could result in unclean dishes and potential for food-borne illness. The LXi Series Dishwasher Instructions dated 9/2010, indicated wash temperature should be above 150°F. The dish machine is identified as having a built-in 70°F booster heater and requires an incoming water temperature of 110°F to reach the proper rinse temperature (180°F). The Hobart LXi Series label affixed to the dish machines indicated the wash temperature must reach a minimum of 150°F and rinse temperature must reach 180°F for hot water sanitizing. The Warewashing-Mechanical and Manual - Food and Nutrition policy dated 4/26/22, indicated each location is to compare federal regulations, state regulations, and manufacturer's guidelines and write appropriate temperatures on the Dish Machine Temperature Log, and must follow the strictest guideline. The policy identified staff were to check compliance for wash and rinse cycles each meal service and record the temperature on the log.	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The administrator, certified dietary manager, or designee could develop, review, and/or revise policies and procedures to ensure dishwasher temperatures are maintained, educate staff regarding policies and procedures, and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess ability to self-administer medications for 1 of 1 resident (R29) observed to self-administer a nebulizer treatment. Findings include: R29's admission Minimum Data Set (MDS) dated 4/27/22, indicated R29 had mild cognitive impairment and diagnoses of chronic obstructive pulmonary disease (COPD) and dementia. R29's provider order summary dated 6/29/22, indicated R29 had an order for Albuterol Sulfate	21565	Corrected.	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 16 Nebulization solution 2.5 milligrams (mg)/3 milliliters (ml) 1 dose via mask one time a day for dyspnea (shortness of breath). Document oxygen saturations, pulse, respirations, and lung sounds pre and post administration and record total time spent with resident on treatment. R29's medical record lacked evidence of R29's ability to self-administer medications. R29's medication self-administration assessment was requested however was not received. During an observation on 6/29/22, at 7:49 a.m. registered nurse (RN)-A administered R29's oral medications and then set up R29's nebulizer with the albuterol medication as ordered. R29 was up in the wheelchair with the bedside table in front of him. RN-A assessed R29's lungs and obtained vital signs before setting up R29's nebulizer. RN-A stated R29 was "ok to self-administer the nebulizer and just needs set up". RN- further stated an assessment was completed to determine R29's ability to administer, but a provider order was not required. RN-A instructed R29 to close his mouth over the nebulizer to breath and would return when finished. RN-A then left the room at 8:01 a.m. At 8:02 a.m. R29 had set the nebulizer down on the bedside table in front of him and took some sips of water. R29 picked up the nebulizer up for a moment before again setting it back down on the table. R29 then drank some more water and picked up the magazine on his table and started going through the pages. R29's nebulizer remained running while sitting on the bedside table. At 8:07 a.m. RN-A returned and asked if R29 was completed, R29 stated yes. RN-A cleaned the equipment before leaving R29's room.	21565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 17 During an interview on 6/29/22, at 8:31 a.m. RN-B stated an assessment was needed to determine a resident's ability to self-administer medications. If the assessment showed the residents ability, a provider order was obtained. RN-B stated R29 would not be able to self-administer medications or nebulizers. RN-B further stated R29 may be able to hold it, but R29 has dementia, and the nurse needed to stay to ensure the medication was administered. During an interview on 6/29/22, at 12:40 p.m. the director of nursing (DON) stated all residents who self-administer medications were required to have an assessment and teaching to determine if the resident was capable of self-administering medications. Once an assessment was completed and determined appropriate, a provider order was obtained. A facility policy titled Resident Self-Administration of Medication, revised 10/15/21, directed staff to complete the resident self-administration of medications assessment, complete an interdisciplinary review, and obtain a provider order prior to self-administering medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed to ensure ability to safely self-administer medications; then provide staff education. The quality assurance committee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 19, 2022

CMS Certification Number (CCN): 245279

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

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 August 5, 2022 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
July 11, 2022

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: June 29, 2022

Dear Administrator:

On June 29, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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) 201-3792 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 September 29, 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 December 29, 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,

Kamala Fiske-Downing

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

Electronically delivered
July 11, 2022

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

Re: State Nursing Home Licensing Orders
Event ID: 9Q2111

Dear Administrator:

The above facility was surveyed on June 26, 2022 through June 29, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_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:

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) 201-3792 Mobile (651)238-8786

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.

Sincerely,

Kamala Fiske-Downing

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