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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: AB6T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00961

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245314**

2.STATE VENDOR OR MEDICAID NO.
(L2) **841820900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINTHROP**
(L4) **506 HIGH STREET**
(L5) **WINTHROP, MN** (L6) **55396**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/16/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **32** (L18)
13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 04/21/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 04/21/21 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/06/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 21, 2021

CMS Certification Number (CCN): 245314

Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

Dear Administrator:

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

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

Effective March 30, 2021 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 21, 2021

Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

RE: CCN: 245314
Cycle Start Date: February 17, 2021

Dear Administrator:

On April 16, 2021, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: AB6T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L4) **506 HIGH STREET**
(L5) **WINTHROP, MN** (L6) **55396**

4. TYPE OF ACTION: **2** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/19/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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FISCAL YEAR ENDING DATE: (L35)
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To (b) :

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Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Julie Halvorson, HFE NE II 03/31/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 04/02/2021 (L20)

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

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

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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
05/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 17, 2021

Administrator
Good Samaritan Society - Winthrop
506 High Street
Winthrop, MN 55396

RE: CCN: 245314
Cycle Start Date: February 19, 2021

Dear Administrator:

On February 19, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 19, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 19, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	245314	A. BUILDING _____ B. WING _____	C 02/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 02/16/21 through 02/19/21, a survey for compliance with CMS Appendix Z Emergency Preparedness was conducted during a recertification survey. The facility was not not compliance with the Appendix Z Emergency Preparedness, Requirements for Long-Term Care (LTC) Facilities.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2)	E 041		3/30/21

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

Electronically Signed | 03/22/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	C 02/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 1 Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org,	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	C 02/19/2021

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

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E 041	Continued From page 2 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on the fire marshals record review and staff interview, the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 Section 8.3.4 the Standard for Emergency and Standby Power Systems. This deficient practice had the potential to affect all 32 current residents in the facility, staff and visitors. Findings include: On 02/17/21, between 11:00 a.m. to 3:30 p.m., documentation review, record review, and director of environmental services interview	E 041	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	C 02/19/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 3 indicated: 1. There were no weekly standby power system inspections between 09/03/20 - 09/15/20. 2. There were no monthly standby power system records for October and November 2020.	E 041	7305 of the State Operations Manual. Non-compliance in generator testing directly attributed to lapse in coverage of maintenance. New director hired and restored compliance from start date. Routine generator inspections will be added to Tells Maintenance log and populate when due. Testing will continue to be monitored and executed moving forward by environmental services director. Inspection logs will be monitored weekly and brought to monthly QAPI committee for review and further recommendation for 3 months.	
F 000	INITIAL COMMENTS On 2/16/21, through 2/19/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found 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 without deficiency cited due to actions implemented by the facility prior to survey. H#5314018C (MN61969) The following complaints were found to be UNSUBSTANTIATED: H#5314014C (MN50644) H#5314015C (MN57797) H#5314016C (MN57968) H#5314017C (MN61852) The facility's plan of correction (POC) will serve	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - WINTHROP	506 HIGH STREET WINTHROP, MN 55396

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F 000	Continued From page 4 as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		3/30/21

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	245314	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 550	Continued From page 5 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 19 residents (R10) who needed feeding assistance and was not provided assistance in a timely manner and was left unattended during the meal service. Findings include: R10's face sheet dated 2/19/21, indicated readmission date of 12/8/20. R10's diagnoses included multiple sclerosis (a disease that affects the central nervous system), pressure ulcer of sacral region stage 4, contracture of muscle (permanent shortening of a muscle or joint) multiple sites, and abnormal weight loss with severe protein-calorie malnutrition. R10's quarterly Minimum Data Set (MDS) assessment dated 12/14/20, indicated R10 had moderately impaired cognition and required total	F 550	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. F550 (D) – Food will be served and brought to R10 when R10 is prepared to eat his meal. For R10, assistants are not to leave room	

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F 550	Continued From page 6 assistance of one person with eating. R10's care plan dated 5/19/20, indicated R10 required feeding with assist of one. During observation of dining on 2/16/21, at 5:22 p.m. meal trays were observed leaving the dining area at 5:20 p.m., and a meal tray was placed on R10's bedside table at 5:22 p.m. On 2/16/21, at 5:59 p.m., R10 indicated no one had come into help him eat yet. R10's meal tray remained on bedside table with lid covering plate and 3 beverages. R10 indicated he was hungry and would eat something if someone came to assist him. On 2/16/21, at 6:10 p.m., nursing assistant (NA)-B, indicated there are 2 aides on the evening shift, but they have a good routine that works. When questioned if R10 had been offered any assistance with feeding, NA-B indicated he was heading their next, but had to help assist others in the dining room then entered R10's room. On 2/16/21, at 6:13 p.m., NA-B left R10's room. During interview on 2/16/21, at 6:14 p.m., R10 indicated his soup was no longer warm and he was unsure where NA-B went. On 2/16/21, at 6:22 p.m., NA-B returned to R10's room and assisted him with eating. On 2/16/21, at 6:25 p.m., NA-B again left R10's room. During interview on 2/16/21, at 6:26 p.m., R10 indicated he was not done eating yet but NA-B	F 550	until R10 is done eating. For all other residents, who require feeding assistance, we will follow the same practice. Meals not to be removed from warming devices/ cart until residents are prepared to eat. Assistants also are not to leave residents while feeding until resident is done eating. Education to be provided to nursing staff regarding not removing meal trays from the cart or removing the warming device/cover off of the tray until residents are prepared and ready to eat; and assistants are not to leave residents who require feeding assistance until the resident is done eating. This education will be provided to nursing staff by DON or designee by 3/30/2021 or prior to next shift worked. Observation or interview audits during random meal times will be completed daily for 5 days, then weekly X 3, then monthly X 2 by the DON or designee. Results will be brought to QAPI committee for review and further recommendation.	

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F 550	Continued From page 7	F 550		

left his room again. R10 indicated the interruptions and waiting up to an hour occurs every evening and it upsets him.

During interview on 2/16/21, at 6:28 p.m., NA-B was in the hallway and when asked if he was done assisting R10 with his meal indicated he was doing the best he can and R10 wasn't eating much tonight and tends to eat more with lunch and breakfast. NA-B then returned to R10's room to assist.

During interview and observation 2/16/21, at 6:35 p.m., NA-B was observed removing the tray from R10's room. NA-B indicated R10 at 25% of his meal. NA-B indicated mealtime can be very busy and sometimes the residents have to wait but they do the best they can.

During interview 2/16/21, at 6:36 p.m., NA-C indicated mealtime is challenging but slowly they do get all the residents fed. NA-C also indicated people have to wait, but we eventually get to them and assist them.

During observation and interview on 2/19/21, at 8:23 a.m., NA-A was observed passing meal trays and left R10's tray on the cart indicating she did not have time right now to assist R10 so the tray was taken back to kitchen. R10 was lying awake watching television in his room. R10 indicated he was hungry and ready to eat breakfast.

During observation on 2/19/21, at 8:48 a.m., NA-A returned to R10's room with his tray and provided assistance with eating. R10 ate 75% of his meal.

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F 550	Continued From page 8 During interview on 2/19/21, at 10:50 a.m., the director of nursing indicated they do not use feeding assistants at the facility and NA's are expected to assist timely with feeding. Requested policy on dignity and dining or Bill or Rights and received Minnesota Department of Health Combined Federal and State Bill of Rights which includes: - A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident ' s individuality. The facility must protect and promote the rights of the resident.	F 550		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		3/30/21

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F 582	Continued From page 9 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to 1 of 1 resident (R14) whose Medicare A coverage ended, and the residents remained in the facility.	F 582	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	

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F 582	Continued From page 10 Findings include: R14's Centers for Medicare and Medicaid Services (CMS)-10123 was signed by R14's family representative as received on 2/10/21 and identified the last effective date of coverage of current services was 2/12/21. This document lacked the reason for discontinuation of Medicare A benefits, although R14 remained in the facility. R1's medical record lacked any evidence a SNFABN 10055 had been provided to inform R14 of the estimated cost per day, or an explanation of the extended care services or items to be furnished, reduced, or terminated. On 2/17/21, at 10:01 a.m., the director of nursing (DON) indicated she was the one who completed the form and had no idea what the CMS-10055 was. The DON indicated the Minimum Data Set (MDS) coordinator is supposed to complete these forms, but they currently do not have a person in the position. At 10:04 a.m., the DON returned with a blank CMS-10055 form and said she had just found this. The DON contacted the previous MDS coordinator who indicated she was not aware this form existed. The DON indicated they would now use this form for those residents who stay in the building but confirmed the incorrect form was being used.	F 582	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. F582 (E) - The correct beneficiary notice (CMS-10055) for R14 was issued on 3/19/2021. For all residents who were discharged in the last 30 days, the correct beneficiary notice (CMS-10055) will be issued by 3/21/2021. For all future resident discharges, the correct beneficiary form (CMS-10055) will be issued. Education will be provided regarding the correct beneficiary notice (CMS-10055) to be issued to residents on discharge from skilled services who continue to stay in the facility. This education will be provided to nursing staff, specifically MDS nurse, by the DON by 3/30/2021. Beneficiary Notice audits will be completed weekly x 6 weeks to ensure that correct beneficiary notices have been issued upon discharge from skilled services by the DON or designee. Results will be brought to QAPI committee for review and further recommendation.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		3/30/21

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F 657	Continued From page 11 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan was revised to address fall interventions for 1 of 2 residents (R4) reviewed for falls. Findings include: R4's face sheet printed 02/19/21, indicated R4's medical diagnoses included dementia with behavior disturbance, restlessness and agitation,	F 657	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	

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F 657	Continued From page 12 anxiety disorder, and difficulty walking. R4's annual Minimum Data Set (MDS) assessment dated 11/17/20, indicated R4's brief interview for mental status (BIMS) questionnaire score of 99, indicating severe impaired cognition and unable to complete the interview. R4 had verbal behaviors towards others and herself. R4's activities for daily living (ADL) indicated R4 required extensive to total assistance with all ADL's. R4 had frequent bowel and bladder incontinence. R4's care plan last revised 12/8/20, indicated R4 had impaired cognitive function related to diagnosis of dementia short and long term memory loss, impaired decision making skills, and limited insight into personal well-being and safety. R4 had several documented falls with fall prevention interventions identified however the care plan was not updated to include intervention. Falls included the following incidents: Progress notes dated 4/9/20, indicated fall from recliner - intervention: keep frequently used items within reach. Progress note dated 6/9/20, indicated fall from recliner - intervention: use baby doll as distraction. Progress note dated 9/16/20, indicated fall from recliner - intervention: hourly rounding while resident is awake. Progress note dated 9/22/20, indicated fall from bed - intervention: place fall mat next to bed when	F 657	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. F657(D) – The Care Plan for R4 has been reviewed and updated to include fall interventions. For all other residents with falls in the last 30 days, care plans will be reviewed to ensure appropriate interventions have been implemented. A new root cause analysis tool will be completed by the Interdisciplinary Team for each fall reviewed to determine root cause and appropriate intervention. Education will be provided by the DON or designee for the licensed nursing staff regarding the Root Cause Analysis Tool, along with education on the process of implementing and documenting in the care plan the falls intervention to prevent recurrence by 3/30/2021. Care Plan audits for fall interventions will be completed weekly x 4 weeks, then monthly X 3 by the DON or designee. Results will be brought to QAPI committee for review and further recommendation.	

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F 657	Continued From page 13 resident is in bed. During an observation on 2/17/21, at 12:30 p.m. R4 was sitting in her recliner holding her baby doll and trying to give the doll a drink of water. R4 continues talking with the doll and appears to be asking the doll questions. R4 continued to kiss and caress the doll throughout the observation. During an interview on 2/19/21, at 9:16 a.m. nursing assistant (NA)-D stated, staff do frequent observations when walking by R4's room. They also use music as a distraction and keep her call light close. NA-D stated there are no other interventions noted in the nursing assistant care plan in PointClickCare electronic medical record. During an interview on 2/19/21, at 3:15 p.m. the director of nursing (DON) stated it has been difficult to keep up with care planning. Since starting in her new position there has been a tremendous amount of work that has needed to be completed. DON stated, we just got behind with R4's fall prevention care planning. The facility Fall Prevention & Management - Rehab/Skilled policy dated 06/24/20, directed after a fall to use the Falls Tool UDA care plan the appropriate interventions and communicate fall risks and interventions to prevent future falls. The facility Care Plan - Rehab/Skilled policy dated 10/16/20, directed the care plan to be modified to reflect required care for the resident.	F 657		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		3/30/21

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F 755	Continued From page 14 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a system for periodic reconciliation of controlled substance medications of 1 of 2 emergency kits (E-Kit) to prevent potential loss or diversion. This had the potential to affect any of the 19 residents residing in the facility who may require controlled	F 755	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	

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F 755	Continued From page 15 medications from the refrigerated E-Kit. Findings include: A tour of the medication storage room was conducted with registered nurse (RN)-B on 02/17/21, at 8:48 a.m. At the time of the tour, a refrigerator was observed in the medication room which contained a small clear plastic box identified by RN-B as the facility's refrigerated E-Kit. The refrigerated E-Kit had a combination lock and a white plastic numbered tag on the clasp of the box. A label affixed to the box indicated Ativan and Insulin as the contents. RN-B indicated that once the refrigerated E-Kit is opened, there are two red numbered tags of which one is applied to the clasp and the box is re-locked. RN-B further stated Thrifty White Pharmacy is contacted and they will bring out a new box and exchange the opened box. RN-B stated the white nor the red numbered tag is documented in the Narcotic Book. RN-B further stated it also is not counted or observed during the other controlled medication reconciliation process. The facility medication reconciliation book was reviewed and was noted to not include counting for the refrigerated E-Kit or documenting security tag numbers. The facility's Medications: Controlled policy dated 12/11/20, directed controlled substances are counted and verified by two licensed staff each time the medication control keys change from one staff to another.	F 755	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. F755 (F) – The refrigerated controlled substance e-kit was added to the Nurse to Nurse Controlled Drug E-kit Verification Record to ensure that it is included in the controlled substance verification and reconciliation. All residents receiving controlled substances have the potential to be affected. Education will be provided to all nursing staff regarding the Nurse to Nurse Controlled Drug E-kit Verification Record for all Controlled Drug E-kits, and of the importance of completing all E-kit reconciliations by the DON or designee by 3/30/202. Controlled Substance Verification Record audits will be completed daily X5 days, the weekly X3 weeks, then monthly X2 by the DON or designee. Results will be brought to QAPI committee for review and further recommendation.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)	F 849		3/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING _____ B. WING _____	C 02/19/2021

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

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F 849	Continued From page 16 §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and	F 849		

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F 849	Continued From page 17 met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC	F 849		

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F 849	Continued From page 18 facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality	F 849		

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F 849	Continued From page 19 of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by:	F 849		

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F 849	Continued From page 20 Based on observation, interview and record review, the facility failed to ensure the necessary coordination of services between the facility and hospice agency was completed by reviewing and incorporating the plans for services provided by hospice for 1 of 1 resident (R15) reviewed for hospice. Findings include: R15's facesheet printed 2/19/21, included diagnoses of prostate cancer, major depressive disorder, dementia, and stroke with aphasia (loss of ability to express speech). R15's admission Minimum Data Set (MDS) assessment dated 12/30/21, indicated R15's BIMS (brief interview for mental status) was not able to be assessed. R15 had minimal difficulty hearing, unclear speech, was rarely or never able to make self understood, and was rarely or never able to understand others. R15 required extensive assistance of one or two staff for all activities of daily living. R15's facility plan of care with date range of 12/24/20 - 4/14/21, had one reference to R15 being on hospice: R15 had potential for psychosocial well-being related to declining health and recent admission to hospice. Goal and interventions include: R15 will express contentment, comfort and/or satisfaction with quality of life. Adjust environment to promote sleep; provide opportunity for rest, TV, and activities that promote relaxation. Provide opportunities for resident and family to participate in care. R15's physician orders dated 12/24/20, indicated	F 849	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. F849 (D) – The Hospice care plan, progress notes, and schedule were obtained and incorporated into the resident's care plan on 3/22/2021 for R15. For all other Hospice residents, the facility will review the resident's care plans to ensure hospice care plans are incorporated into the resident SNF care plan, progress notes have been received, and that schedules are in each individual hospice folder. Education of the process explained above will be provided to the admission nurse and rest of nursing staff by DON or designee by 3/30/2021. Audits will be completed to ensure incorporation of hospice care plans into resident's SNF care plan, progress notes have been received, and schedules are in the hospice binders weekly x 4 weeks, then monthly X 3 by DON or designee.	

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F 849	Continued From page 21 an order for hospice/comfort care. During multiple observations from 2/16/21 to 2/19/21, R15 was resting/asleep in bed or sitting up to eat. R15 was observed to moan quietly when turned from side to side in bed.. During an interview on 2/18/21, at 10:45 a.m. registered nurse (RN)-A stated she did not know what days staff from the hospice agency came to the facility to see R15. RN-A stated when a hospice nurse came for a visit, she informed the facility nurse of her next visit, but those dates were not written anywhere. When asked how other nurses would know when to expect a visit, RN-A stated they wouldn't. RN-A was unaware if R15 had a hospice care plan or physician orders from the hospice agency. RN-A looked for these documents in R15's paper hospice folder at the nurse's station but the folder contained minimal documents and did not include documents pertaining to R15's care or health condition: no orders, care plan, assessments or nurse progress notes. During an interview on 2/18/21, at 12:54 p.m. the director of nursing (DON) stated the facility should have a hospice care plan on file for a resident in hospice care. The DON looked for R15's care plan in the electronic medical record (EMR) and was not able to find it. The DON was not able to find nurse progress notes from the hospice agency which would provide ongoing updates pertaining to R15's health status. The DON was able to locate hospice orders for comfort medications dated 12/24/20, in a section of the EMR called Resident Spaces. However, these orders were not incorporated into R15's regular orders that a nurse would refer to on a	F 849	Results will be brought to QAPI committee for review and further recommendation.	

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F 849	Continued From page 22	F 849		

daily basis. The DON admitted the facility did not have R15's hospice care plan or nurse progress notes and admitted nursing staff would likely not know about R15's hospice orders located in EMR (Resident Spaces).

On 2/19/21, at 9:30 a.m. the DON provided R15's hospice care plan and nurse progress notes (a stack the approximate size of a ream of paper) which were obtained from the hospice agency.

During an interview on 2/19/21, at 10:48 a.m. licensed practical nurse (LPN)-A stated she did not know if R15 had a hospice care plan or hospice orders. LPN-A went to the nurse's station and obtained R15's hospice folder, but they were not in the folder. LPN-A looked in the electronic medical record but there was no care plan or orders pertaining to hospice care. When asked how hospice nurses communicated R15's health status, LPN-A stated hospice staff kept a notebook in R15's room and wrote in it each time they came, but admitted those notes were informal notes, primarily for R15's wife.

During an interview on 2/19/21, at 11:43 a.m. (RN)-B stated she did not know if R15 had a hospice care plan or hospice orders. When asked how she would obtain comfort orders for R15 as he further declined, such as orders for agitation, hallucinations, anxiety, nausea or vomiting, RN-B stated she would call the hospice agency. RN-B was unaware that the hospice agency had provided comfort orders for R15. In addition, RN-B stated she had never seen nurse progress notes from the hospice agency. When asked if she knew which days the hospice nurse, massage therapist, chaplain and nursing assistant came to the facility to visit R15, RN-B

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stated she did not know.

During an interview on 2/19/21, at 2:12 p.m. the DON admitted collaboration between the facility and the hospice agency could be better, admitting the facility did not have the hospice care plan or nurse progress notes at the facility until surveyor asked about them. While the facility did have comfort orders in a different location in the EMR, they were not part of R15's regular orders and nursing staff were not aware of them. The DON stated there was a calendar to let staff know when hospice staff was coming to see R15, but when the DON looked in the calendar book, there was no entry for 2/18/21, when the hospice nurse had been at the facility to see R15. The DON admitted the use of the calendar book was not a consistent process. The DON acknowledged that improved collaboration is needed between the facility and the hospice agency for the benefit of R15 and his family.

Documents received from the DON on 2/19/21, after requested from the hospice agency:
1. Physician certification of terminal illness dated 12/24/20, indicated R15 had progressive dementia (advanced) and progressive metastatic prostate cancer causing on-going weakness, weight loss, inability to participate in therapy. His condition was terminal and his life expectancy was estimated to be less than six months.
2. Hospice orders for the facility, including frequency of hospice visits indicated:
--nurse: two times per week
--home health aide: one time per week
--social worker, chaplain, massage and music therapy: one to four times per month
3. Hospice plan of care: a 5 page document outlining the care the agency would provide.

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F 849	Continued From page 24 4. Nurse progress notes. While the facility had these orders in a separate location of the EMR, nursing staff was not aware of them: --Hospice agency orders titled: "comfort pack assessment and prescription authorization form for the terminally ill hospice patient," signed and dated 12/24/20, included orders for seven medications to treat or provide comfort from constipation, agitation, hallucinations, secretions, anxiety, nausea, insomnia, pain, and shortness of breath. Facility policy titled Hospice Services Provided in a Skilled Nursing Facility, with revised date of 11/23/20, indicated: --Hospice: hospice care addresses symptom management, coordination of care, communication and decision making, clarification of goals of care and quality of life for the dying resident and their family. --A coordinated comprehensive plan of care shall be jointly developed by the facility and hospice. The plan of care must include directives for managing pain and other symptoms associated with hospice care. --The hospice team and facility employees must communicate with each other when any changes are made to the plan of care. --The hospice information/documentation should be integrated into the EMR. Hospice documention received from the hospice agency will be scanned and retrieved in Resident Spaces.	F 849		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Winthrop was found to be NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2021

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

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K 000	Continued From page 1 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Winthrop is a one-story building with a partial basement. The original building was constructed in 1965, with building additions constructed in 1966, 1994, 1995, and 2006. The facility is fully fire sprinkler protected and was determined to be of Type II(111) construction. Previously the 2006 addition was surveyed as a separate building and has now been determined to be surveyed as one. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 19 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222		3/30/21

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K 222	Continued From page 3 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the proper operation of exit door locking devices. NFPA 101, Life Safety Code, 2012 edition section 7.2.1.6.1.1. This deficient practice could cause the door not to open properly and could affect an undetermined amount of residents and staff. Findings include: During the facility tour between 11:00 AM to 3:30 PM on 02/17/2021, observations revealed: 1) The delayed egress doors in 2 resident wings would not open within 15 seconds. 2) The delayed egress doors did not have the proper signage stating, "Push until alarm sounds, door can be opened in 15 seconds."	K 222	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. K222 NFPA 101 Egress Doors	

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K 222	Continued From page 4 These deficient conditions were confirmed by the Director of Environmental Services.	K 222	It is the policy of the facility to maintain Egress Doors in safe working order. Corrective Action will include: Tee – Jay North Door Inc. was contracted to fix our deficiency. Egressed doors were fixed to open in 15 seconds and signage was posted. Date of completion: 2/26/2021 Monthly door inspection will be included in our facility preventative maintenance program and performed per NFPA requirements. The Environmental Services Director and/or designee will conduct annual door inspection to meet NFPA standards and requirement. All egress doors identified as not meeting this requirement will be repaired immediately. Assurance of On-Going Compliance The Environmental Services Director and/or designee as part of the facilities monthly preventative maintenance will conduct door inspections weekly per the location's preventative maintenance program.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced	K 345		3/30/21

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K 345	Continued From page 5 by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 101 Life Safety Code 2012 edition, sections 9.6.1.3 and 9.6.1.5, and NFPA 72 National Fire Alarm Code 2010 edition, section 14.4.5.3.2. This deficient practice could affect 32 of 32 residents, as well as an undetermined number of staff and visitors to the facility. Findings include: During documentation review between 11:00 AM to 3:30 PM on 02/17/2021, the facility was unable to locate any documentation of a sensitivity report for the last two years at the time survey. This deficient conditions was confirmed by the Director of Environmental Services.	K 345	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. K345 NFPA 101 Fire Alarm System – Testing and Maintenance It is the policy of the facility to continuously maintain in reliable operating condition Fire Alarm Systems and to ensure Fire Alarm Systems are inspected, tested and maintained periodically. Corrective action will include: Johnson controls came to the facility to complete Smoke detector sensitivity report. Report was added to fire safety book. Date of completion: 3/2/2021 Assurance of On-Going Compliance The Environmental Services Director will schedule and assure that semi -annual inspection, testing and maintenance is performed to meet this requirement and as identified in our preventative maintenance program.	
K 712 SS=F	Fire Drills	K 712		3/30/21

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K 712	Continued From page 6 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct fire drills at least quarterly on each shift under varied conditions as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 32 residents and an undetermined amount of staff and visitors. Findings include: During documentation review between 11:00 AM to 3:30 PM on 02/17/2021, documentation review revealed the following: 1) Fire drills were not conducted quarterly on each shift 2) Fire drill reports did not document the integrity of the alarm transmission. This deficient conditions was confirmed by the Director of Environmental Services.	K 712	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. K712 NFPA 101 Fire Drills It is the policy of the facility to perform and assure Monthly/Quarterly Fire Drills conducted in accordance with NFPA standards and requirements.	

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K 712	Continued From page 7	K 712	Corrective action will include MEASURES and changes used to prevent a recurrence: 1. Fire drills to be completed on each shift at least once quarterly. Education completed by administrator with environmental services director on 3/16/2021. 2. Preventative maintenance program and instructions will be updated to include the following: a. Monthly first, second and third shift drills 3. Fire drills to be completed on each shift at least once quarterly. Education completed by administrator with environmental services director on 3/16/2021. 4. Quarterly fire drills will be conducted one per shift per quarter. Drill will be no closer than 2 hours apart from the last recorded drill. Drills will also be conducted on different dates, times and locations. Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct and assure fire drills are performed to meet this NFPA standards and requirements and as identified in our preventative maintenance program. The facility safety committee will review and oversee documentation that shows that the aforementioned inspections and maintenance are performed as required. The committee will monitor the monthly fire drills for three months The facility administrator will monitor and	

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K 712	Continued From page 8	K 712	verify monthly fire drills are completed and documented per assigned scheduling.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect that the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99 Health Care Facilities Code 2012 edition, sections 4.1 through 4.3. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between 11:00 AM to 3:30 PM on 02/17/2021, documentation review and staff interview revealed the required fundamental risk assessment of NFPA 99, which had not been started at the time of the survey. This deficient conditions was confirmed by the	K 901	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. K901 NFPA 101 – Building Systems Categories It is the policy of this facility to complete	3/30/21

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K 901	Continued From page 9 Director of Environmental Services.	K 901	and review annually the Life Safety Code risk assessment as required by Code. Corrective Actions: 1. Environmental service director to complete NFPA 99 report by 3/22/2021. Assurance of On-going compliance: 1. Task is now part of the location's preventative maintenance program scheduled to be reviewed according code timing requirements.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	K 914	Preparation and execution of this	3/30/21

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K 914	Continued From page 10 electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 32 of 32 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: During documentation review between 11:00 AM to 3:30 PM on 02/17/2021, record review and staff interview revealed there was no documentation for the annual receptacle inspection in resident rooms. This deficient conditions was confirmed by the Director of Environmental Services.	K 914	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. K914 NFPA 101 Electrical Systems – Maintenance and Testing It is the policy of the facility to maintain the usage of all electrical systems in accordance with NFPA standards and requirements. And accept this facilities credible allocation of compliance and correct the citation K914 Corrective action will include: 1. The facility preventative maintenance program and instructions has been updated to include annual receptacle testing and inspections. 2. Electrical Receptacle inspection will include Polarity, Grounding and Grounding tension force of not less than 4 oz. 3. The Environmental Services Director will perform annual receptacle inspections and testing: Completed on 3/26/2021 Assurance of On-Going Compliance The facility safety committee will review and oversee documentation that shows	

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K 914	Continued From page 11	K 914	that the aforementioned inspections are performed as required. The committee will monitor the annual electrical receptacle inspections (annually).	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 918		3/30/21

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K 918	Continued From page 12 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110, the Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient practice could affect the safety of all 32 patients and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: During documentation review between 11:00 AM to 3:30 PM on 02/17/2021, record review and staff interview revealed: 1) There was no weekly inspection between the week of 09/03-09/15/2020. 2) There were no monthly records for October and November 2020. This deficient conditions was confirmed by the Director of Environmental Services.	K 918	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. K918 NFPA 101 Electrical Systems – Essential Electrical Systems It is the policy of the facility to perform Monthly and Annual Emergency Generators Inspections and Testing to assure Essential Electrical Systems “Emergency Generators” are tested in accordance with NFPA standards and requirements. Non-compliance in generator testing directly attributed to lack of coverage in maintenance. New director hired and restored compliance from start date. Testing will continue to be monitored and executed moving forward. Corrective action will include MEASURES and changes used to prevent a	

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K 918	Continued From page 13	K 918	recurrence: 1. Preventative maintenance program and instructions will be updated to include the following: a. Weekly visual inspections will be conducted according to the preventative maintenance task included in the location's preventative maintenance program. b. Monthly validation and testing of emergency generator to include KW calculations, voltage and amperage logs, battery Electrolyte or Conductive testing and log. Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct and assure emergency generator test are performed to meet this NFPA standards and requirements and as identified in our preventative maintenance program. The facility safety committee will review and oversee documentation that shows that the aforementioned inspections and maintenance are performed as required. The committee will monitor the monthly inspections for three months.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled	K 920		3/30/21

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

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K 920	Continued From page 14 by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that multiple outlet adapters are used in accordance with the 2012 edition of NFPA 99 section 10.2.4.2.1, and the use of power strips comply with 10.2.3.6. This deficient practice could affect 1 of the 32 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 11:00 AM to 3:30 PM on 02/17/2021, observations revealed two unapproved multi-plug adapters were being used in room 124 for medical devices, an oxygen concentrator, and a nebulizer. This deficient conditions was confirmed by the Director of Environmental Services.	K 920	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. K920 Electrical Equipment – Power Cords and Extension Cords	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245314	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 920	Continued From page 15	K 920	It is the policy of the facility to maintain the usage of all Power/extension Cords and power strips in accordance with NFPA 101 standards and requirements. Corrective action will include MEASURES and changes used to prevent a recurrence: 1) All power cords and extensions have been removed from resident rooms. New UL 1363 listed extenders have been ordered to replace. Installation date completed by 3/26/2021. 2) Facility inspection of power cords and power strips has been included in the facilities preventative maintenance program. 3) The Environmental Services Director and or designee will conduct an inspection of the entire facility to assure all power/extension cords and power strips are in compliance with NFPA 101 standards. Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct ongoing power/extension cords and power strips inspection to assure NFPA standards and requirements and as identified in our preventative maintenance program.	