Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 19, 2024

Administrator
Good Samaritan Society Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

RE: CCN: 245285
Cycle Start Date: December 12, 2024

Dear Administrator:

On December 12, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Regional Operations Supervisor
Metro Team C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 March 12, 2025 (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 June 12, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245285	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY INVER GROVE HEIG	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	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 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 ensure the required Notice of Medicare Non-Coverage (NOMNC; CMS-10123) was provided upon termination of Medicare A coverage for 2 of 3 residents (R41, R42) reviewed for beneficiary notices. Findings include: The Centers for Medicare and Medicaid (CMS) Form Instructions for the Notice of Medicare Non-Coverage (NOMNC), located on CMS' website, instructed a Medicare provider must deliver a completed copy of the NOMNC to beneficiaries receiving covered services (i.e., skilled nursing, rehab). The instructions outlined for, "Plans only," the notice be provided at least two calendar days prior to cessation of Medicare A coverage adding, "A NOMNC must be delivered even if the beneficiary agrees with the termination of services."

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245285	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 12/12/2024

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 1

R41's admission Minimum Data Set (MDS), dated 8/22/24, identified R41 admitted to the care center on 8/16/24 from the acute care hospital. Further, the MDS identified the admission as the most recent Medicare stay.

R41's progress notes, dated 8/16/24 to 12/1/24, identified the following:

On 8/22/24, R41 was recorded as alert and oriented. The note outlined R41's discharge plan was listed as, "Either home of to a new ALF in East Bethel." The note recorded a "X" mark next to, "Yes," with dictation corresponding reading, "Is a discharge plan in place for return to community?" The note did not indicate a date of discharge.

On 9/3/24, R41 was recorded as having a recent COVID-19 infection. R41's discharge plan was outlined which recorded, "Resident will be discharging hopefully later this week to Cedar Creek ALF in East Bethel."

On 9/11/24, R41 was recorded as having discharged to the ALF.

However, R41's medical record was reviewed and lacked evidence R41 was provided a CMS-10123 prior to discharge to ensure her rights were explained and/or an opportunity provided to appeal the termination of Medicare A coverage.

R42's admission MDS, dated 8/8/24, identified R42 admitted to the care center on 8/2/24 from the acute care hospital. Further, the MDS identified the admission as the most recent Medicare stay.

R42's progress notes, dated 8/2/24 to 12/1/24, identified the following:

On 8/8/24, R42 was recorded as having intact cognition with a discharge goal listed, "Home to her apartment after surgery and further rehab." The note recorded a "X" mark next to, "Yes," with dictation corresponding reading, "Is a discharge plan in place for return to community?" The note did not indicate a date of discharge.

On 8/23/24, a care conference note was listed which identified R42 wished to return home " ... sooner rather than later ... hoping to go home next Friday."

On 8/30/24, R42 was discharged from the care center.

However, R42's medical record was reviewed and lacked evidence R42 was provided a CMS-10123 prior to discharge to ensure her rights were explained and/or an opportunity provided to appeal the termination of Medicare A coverage.

On 12/12/24 at 8:46 a.m., licensed social worker (LSW)-A was interviewed. LSW-A verified they provided the NOMNC for the campus and reviewed R41 and R42, stating both admitted with Medicare A coverage for therapy services. LSW-A explained R41 and R42 both seemed to be a resident initiated discharge as they both

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 2

wanted to discharge the campus to their respective destinations, however, acknowledged both could have remained at the care center and been covered under Medicare A for continued therapy. LSW-A verified both R41 and R42 had left against medical advice (AMA) and a discharge date was known for them in advance of them physically leaving the campus. LSW-A verified neither of them were provided a NOMNC and expressed they weren't provided as they felt the discharges were "resident led." LSW-A stated, moving forward, they would provide the NOMNC to residents to ensure it's given including when the resident wanted to leave (i.e., agreed with end of coverage).

A facility' provided SNF Medicare Part A Advance Beneficiary Notice of Non-Coverage (SNFABN) policy, dated 2/2023, identified the procedure for giving the SNFABN to a resident. However, lacked information on how or when the NOMNC would be provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING _____ B. WING _____	C 12/12/2024

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GOOD SAMARITAN SOCIETY INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(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 12/10/24 to 12/12/24, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. The facility was found in compliance with the requirements. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/10/24 through 12/12/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaint was reviewed with no deficiency issued: H52851680C (MN00108497) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/24/2024

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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F 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 553 SS=E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced	F 553		1/13/25

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F 553	Continued From page 2 by: Based on interview, and document review, the facility failed to provide the opportunity for 4 of 4 residents (R22, R31, R1, R15) reviewed to participate in care planning and care conferences. Findings include: R22 R22's significant change Minimum Data Set (MDS) dated 11/5/24, indicated severely impaired cognition. R22's medical record was reviewed from 2/10/24 to 12/11/24 and lacked evidence that R22's representative was invited or attended a care conference held during this period. During an interview on 12/10/24 at 2:30 p.m., R22's resident representative (FM)-A stated she was the one who would attend R22's care conferences but she had not been invited to one since 10/23. FM-A stated she would have wanted to participate in a care conference, but none had been offered since last year. R31 R31's quarterly MDS dated 10/10/24, indicated R31 had intact cognition. R31's medical record was reviewed from 6/10/24 to 12/11/24 and lacked evidence that R31 or her representative was invited or attended a care conference held during this period. During an interview on 12/10/24, R31 stated she	F 553	1)A care conference was held for R31 with family representatives on 10/13/24. R1 family was Contacted for a care conference on 12/13/24, care conference is scheduled for 1/21/25. R1 had a care conference with IDT team on 12/17/24. R15 care conference was held 12/23/24, representatives present via telephone. R22 representees was contacted to set up Care conference on 12/20/24, care conference scheduled for 1/7/2025. 2)All residents in this facility have the potential to be affected. A review of residences was completed on 12/20/24 to evaluate if care conferences have been held and representees contacted to attend for the last 90 days. Those found to be affected will have a care conference with representees completed and documented by 1/13/2025. 3)To ensure systemic changes are sustained, the Social Worker will be educated by DON on the facility policy Comprehensive care plan and care conferences. And the importance of ensuring all care conferences are conducted per the regulation by 1/13/25 4)To ensure compliance is sustained, audits will Conducted on 5 random residents weekly x4, who have MDS assessments due to ensure the care conferences are completed and representatives are included in the plan of care. Results will be brought to QAPI for further evaluation on the need to increase, decrease or discontinue audits. 5)Compliance date: 1/13/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 553	Continued From page 3 did not remember being invited or attending a care conference in the last few months but would have wanted to. During an interview on 12/11/24 at 9:55 a.m., licensed social worker (LSW)-A stated that she oversaw inviting the family, guardians, and/or residents to the care conferences. LSW-A stated care conferences were supposed to be held within three weeks after the assessment reference date (ARD) of the MDS to include residents/resident representatives in the care planning process. LSW-A stated she had reviewed both R22's and R31's medical records and they were both due for care conferences but had not had them yet. During an interview on 12/12/24 at 9:35 a.m., the director of nursing (DON) stated LSW-A oversaw care conferences and would be the best resource for questions regarding this. R1 R1's quarterly Minimum Data Set (MDS), dated 10/10/24, indicated R1 had moderately impaired cognition with no hallucinations or delusions present with an admission date of 4/22/17. Diagnoses included: dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), dysphagia (difficulty swallowing foods or liquids), diabetes (disease that results in too much sugar in the blood), depression, anxiety, and osteoporosis (condition that causes the bones to become brittle and fragile). R1's progress notes, dated 5/1/23 to 12/11/24, were reviewed and identified the following:	F 553		

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F 553	Continued From page 4 -10/27/23: Care Conference Note: [R1] and family "were invited, but they could not come today. There is another care conference with [R1] and family scheduled for next." -10/30/23: Care Conference Note: identified family, dietary manager, activities manger, and social services attended care conference. The progress notes lacked evidence having a care conference in 2024. Furthermore, lacked documentation of planning of a care conference. On 12/10/24 at 1:35 p.m., family member (FM)-A indicated they are involved with their mother's care. They indicated they have had only had a couple care conferences in the past year and cannot recall the last one. FM-A indicated they feel as though details about their mom and her likes/dislikes can get lost between staff. On 12/11/24 at 11:16 a.m., licensed social worker (LSW)-A verified the last care conference for R1 was October 2023 and added "I know we have met since then." LSW-A stated she is responsible for care conference and documenting they occurred. LSW-A indicated R1 family visits often and will bring issues to her attention. LSW-A stated, "I do know the importance of having the care conferences and she would have been due at the latest October 31st." R15 R15's quarterly Minimum Data Set (MDS) assessment, dated 11/20/24, indicated R15 had intact cognition with no hallucinations or delusions with an admission date of 8/26/24. Diagnosis included: quadriplegia (condition that causes partial or total loss of movement in all four limbs and the torso), epilepsy (abnormal electrical brain	F 553		

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F 553	Continued From page 5 activity that causes seizures), depression, dysphagia, and chronic pulmonary embolism (condition when a blood clot in the lung doesn't go away). R15's progress notes, dated 7/18/24 to 12/11/24, reviewed and identified the following: -7/18/24: Care Conference Note: in attendance R15, family, friend, DON [director of nursing] and social services for weekly care conferences and planning for surgery. The progress notes lacked evidence having a care conference since 7/18/24, after returning to the facility. Furthermore, lacked documentation of planning of a care conference. On 12/10/24 at 10:21 a.m., R15 stated they have lived here for quite a few years. R15 indicated that they previously had care conferences, and this was something that they liked as they felt more involved. R15 stated they have not had one in several months and would like to be having care conferences. On 12/11/24 at 11:10 a.m., LSW-A verified the last care conference R15 had was in July, right before R15 went to the hospital. LSW-A indicated R15 was considered an admission when she came back from the hospital and should have had a care conference and verified this was not completed. LSW-A verified care conferences should be done with MDS assessment schedules. LSW-A stated she has talked to the daughter and friend since R15 has returned and verified there has not been a care conference since R15 returned from the hospital. LSW-A indicated she was going to try to schedule a "care conference in the next week or something" and verified she has not attempted to schedule it at this time.	F 553		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 553	Continued From page 6 A facility policy titled Comprehensive Care Plan and Care Conferences, revised 12/4/23, indicated residents and their representatives are to be invited to care conferences and right to request meetings.	F 553		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		1/13/25

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	245285	A. BUILDING _____ B. WING _____	C 12/12/2024

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F 609	Continued From page 7 by: Based on interview and document review, the facility failed to immediately report incidents of potential staff to resident abuse to the state agency (SA) within two hours, as required for 1 of 3 residents (R29) reviewed for abuse. Findings include: R29's quarterly Minimum Data Set (MDS) dated 9/25/24, indicated R29 had intact cognition with no delusional behaviors or hallucinations. R29's care plan dated 7/18/24, indicated R29 had a history of paranoia, "accusations against staff", only allowing certain staff to work with her, and manipulating situations and staff. The care plan included goals for R29 of not displaying symptoms such as paranoia, yelling and swearing at staff, refusing care, "accusing staff", and manipulation. The care plan included interventions such as using approaches with R29 to maximize involvement in daily decision-making and activity, stopping care and returning if R29 becomes agitated, and providing care in pairs for staff and resident safety. The care plan did not indicate what accusations had been made by R29 against staff in the past and if these accusations, were allegations of abuse. During an interview on 12/10/24 at 9:43 a.m., R29 stated three staff members at the facility were "nonverbally and verbally abusive, even aggressive" with her. R29 stated that one of these staff members, her aide right now, was verbally abusive towards her today. R29 stated she was fearful of these people caring for her as they said "mean" things to her.	F 609	1)R29 was interviewed on 12/11/24 for allegations of verbal abuse. R29s care plan was updated on 12/11/24 to indicate all alleged abuse allegations should be reported immediately to DON or administrator. 2)All residents at the facility have the potential to be affected by the deficient practice. Any residents that make an allegation of alleged violations will be immediately investigated. 3)To ensure systemic changes are sustained, all staff will be educated by DON or designee on the policy Abuse and neglect. By 1/13/2025. 4)To ensure systemic changes are sustained, audits will Conducted on 5 random residents weekly x4, by DON or designee for Alleged investigations of abuse reporting and investigating, and resident grievances. Results will be brought to QAPI for further evaluation. 5)Compliance date: 1/13/25	

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F 609	Continued From page 8 During an interview on 12/10/24 at 9:49 a.m., the administrator was notified of R29's accusations of verbal/nonverbal abuse by three staff members, one of which was her aide today. The administrator stated R29 had a history of making allegations against staff members and this was care planned. During an interview on 12/10/24 at 1:44 p.m., nursing assistant (NA)-B stated she was the aide in charge of R29's care. NA-B stated that R29 refused to let her perform her daily living activities, but she would enter R29's room by herself to answer R29's call light, give and retrieve her food tray, etc., as she had today. During an interview on 12/11/24 at 10:11 a.m., registered nurse (RN)-A stated he knew R29 had a history of making "accusations" about staff who R29 did not like but did not think R29 had made accusations of staff being abusive towards her. During an interview on 12/11/24 at 10:22 a.m., the administrator stated he had discussed R29's allegations of abuse with his interdisciplinary team but was unsure if the allegation had been investigated. The administrator stated if it had been, it would have been licensed social worker (LSW)-A or the director of nursing (DON) who completed the investigation. LSW-A stated she had not been aware of the allegation of abuse R29 had made, so this is not something she had investigated. During an interview on 12/11/24 at 10:29 a.m., R29 stated no one from the facility had followed up with her regarding the allegations of abuse she had made yesterday, and NA-B had continued to be her aide for the rest of the shift,	F 609		

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F 609	Continued From page 9 so she occasionally entered her room which made her uncomfortable. During an interview on 12/11/24 at 12:04 p.m., the DON stated R29 had a history of making "these accusations" but they should have gone and followed up with R29 to determine if these accusations were new and if a protection plan needed to be placed. The DON stated it was care planned that R29 made false accusations about staff in the past but acknowledged the care plan did not outline if these false allegations had been abuse allegations or when these would be reported. The DON stated she was going to update the care plan, so staff knew what to do when R29 made abuse allegations as this was not currently part of the care plan. On 12/12/24 at 9:36 a.m., the DON stated the facility handled R29's allegations differently related to the past allegations she had made against staff, so they had not reported R29's allegations of abuse to the state agency. The DON stated if it were a different resident, they would have suspended the aide who the allegations were made against immediately to ensure resident safety and then the incident would be reported. The facility's Abuse and Neglect policy dated 7/6/23, indicated that if an abuse allegation was made, it would be reported to the state agency "immediately" but no later than two hours after the allegation was made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		1/13/25

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F 610	Continued From page 10 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure voiced complaints of potential abuse were acted upon, and investigated to ensure an adequate protection plan was provided to ensure freedom from abuse for 1 of 3 residents (R29) reviewed for abuse and neglect. Findings include: R29's quarterly Minimum Data Set (MDS) dated 9/25/24, indicated R29 had intact cognition with no delusional behaviors or hallucinations. R29's care plan dated 7/18/24, indicated R29 had a history of paranoia, "accusations against staff", only allowing certain staff to work with her, and manipulating situations and staff. The care plan included goals for R29 of not displaying symptoms such as paranoia, yelling and swearing at staff, refusing care, "accusing staff", and manipulation. The care plan included	F 610	1)R29 was interviewed on 12/11/24 for allegations of verbal abuse. R29s care plan was updated on 12/11/24 to indicate all alleged abuse allegations should be reported immediately to DON or administrator. Staff were educated on the policy Abuse and neglect on 12/11/24. 2)All residents have the potential to be affected by the deficient practice. As a result, the systemic changes stated below have been implemented to prevent any further risk of affecting additional residents. 3)To ensure systemic changes and sustained, all staff will be re-educated by the DON or designee on the facility policy Abuse and Neglect. by 1/13/25. 4)To ensure systemic changes are sustained, audits will Conducted on 5 random residents weekly x4, by DON or designee for Alleged investigations of abuse reporting and investigating, and	

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F 610	Continued From page 11 interventions such as using approaches with R29 to maximize involvement in daily decision-making and activity, stopping care and returning if R29 becomes agitated, and providing care in pairs for staff and resident safety. The care plan did not indicate what accusations had been made by R29 against staff in the past and if these accusations, were allegations of abuse. During an interview on 12/10/24 at 9:43 a.m., R29 stated three staff members at the facility were "nonverbally and verbally abusive, even aggressive" with her. R29 stated that one of these staff members, her aide right now, was verbally abusive towards her today. R29 stated she was fearful of these people caring for her as they said "mean" things to her. During an interview on 12/10/24 at 9:49 a.m., the administrator was notified of R29's accusations of verbal/nonverbal abuse by three staff members, one of which was her aide today. The administrator stated R29 had a history of making allegations against staff members and this was care planned. During an interview on 12/10/24 at 1:44 p.m., nursing assistant (NA)-B stated she was the aide in charge of R29's care. NA-B stated that R29 refused to let her perform her daily living activities, but she would enter R29's room by herself to answer R29's call light, give and retrieve her food tray, etc., as she had today. During an interview on 12/11/24 at 10:11 a.m., registered nurse (RN)-A stated he knew R29 had a history of making "accusations" about staff who R29 did not like but did not think R29 had made accusations of staff being abusive towards her.	F 610	resident grievances. Results will be brought to QAPI for further evaluation. 5)Compliance date: 1/13/25	

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F 610	Continued From page 12 During an interview on 12/11/24 at 10:22 a.m., the administrator stated he had discussed R29's allegations of abuse with his interdisciplinary team but was unsure if the allegation had been investigated. The administrator stated if it had been, it would have been licensed social worker (LSW)-A or the director of nursing (DON) who completed the investigation. LSW-A stated she had not been aware of the allegation of abuse R29 had made, so this is not something she had investigated. During an interview on 12/11/24 at 10:29 a.m., R29 stated no one from the facility had followed up with her regarding the allegations of abuse she had made yesterday, and NA-B had continued to be her aide for the rest of the shift, so she occasionally entered her room which made her uncomfortable. During an interview on 12/11/24 at 10:36 a.m., the DON stated she had not talked with R29 regarding her abuse allegations yesterday or further investigated it, but she would look into it. At 12:04 p.m., the DON stated R29 had a history of making "these accusations" but they should have gone and followed up with R29 to determine if these accusations were new and if a protection plan needed to be placed. The DON stated it was care planned that R29 made false accusations about staff in the past but acknowledged the care plan did not outline if these false allegations had been abuse allegations or when these would be reported. The DON stated she was going to update the care plan, so staff knew what to do when R29 made abuse allegations as this was not currently part of the care plan. On 12/12/24 at 9:36 a.m., the DON stated the facility handled	F 610		

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F 610	Continued From page 13 R29's allegations differently related to the past allegations she had made against staff, so the facility had not reported R29's allegations of abuse to the state agency. The DON stated if it were a different resident, they would have suspended the aide who the allegations were made against immediately to ensure resident safety and then the incident would be reported. The facility's Abuse and Neglect policy dated 7/6/23, indicated that all alleged or suspected violations/abuse would be thoroughly investigated, and they would put interventions in place to prevent further abuse while the investigation was in progress. The policy indicated if the allegation was employee-to-resident abuse, the employee would be removed from providing direct care to residents and placed on suspension pending the results of the internal investigation.	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655		1/13/25

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F 655	Continued From page 14 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a baseline care plan for smoking for 1 of 1 residents (R189) reviewed who smoked. Findings include: During an interview on 12/10/24, at 11:57 a.m., R189 indicated he smoked cigarettes and was made aware after admission the facility was a	F 655	1)R189 has been discharged from the faculty. 2)All residents who currently or previously smoke have the potential to be affected. All residents who currently or previously smoked will be reviewed. The Tabacco use assessment will be completed, care plans updated, and smoking cessation products will be offered by 1/13/25. 3)To ensure systemic changes are	

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F 655	Continued From page 15 non-smoking facility. R189 stated he has gone outside the building to smoke while being a resident. R189 indicated staff has told him a few different things about smoking which included: must go on the other side of the parking lot to smoke, can't let people see me smoking and just tell people I am going for a walk. R189 stated the staff at the front desk told him, "that as long as she couldn't see me, I could go for a long walk [to smoke]." R189 indicated that over the weekend, "one of the nurses sat by the front window and watched me smoke outside." R189 further indicated the "head of nursing came and told me today that I can't smoke here" and indicated no staff have discussed or offered any nicotine replacement therapy since admission. R189 stated he has smoked "forever." R189 stated he was able to manage his own cigarettes without burning himself and has not sustained any burns. R189's facility Admission Record, printed on 12/11/24 indicated R189 was admitted to the facility on 12/7/24. Diagnoses included: nicotine dependence. R189's care plan, printed 12/11/24, indicated the following: -Date initiated 12/10/24: Focus: "The resident attempts to use tobacco products outside of facility E/B smoking on facility grounds" with an intervention of "resident education to that smoking is not allowed on facility grounds. Staff will continue to encourage resident to not smoke of facility grounds." R189's Nursing Admit Re-Admit Data Collection, dated 12/7/24, identified R189 as a current tobacco user with a radio-button question answered, "yes". The data collection tool lacked	F 655	sustained all nursing staff will be re-educated by the DON or designee on the facility policy Smoking and tobacco use by 1/13/2025 4)Audits will be conducted on 5 random residents by DON or designee for Tabacco use weekly x4. Results will be brought to Qapi for further evaluation. 5)Compliance by 1/13/25	

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F 655	Continued From page 16 evidence of any further questions about tobacco use. R189's progress notes, dated 12/7/24 to 12/12/24, were reviewed and identified the following: -12/9/24: "LATE ENTRY: Writer was informed resident was going outside to smoke. Resident was educated that this is a no smoking facility and the is not allowed to smoke at the facility. Resident stated he understood the education." On 12/11/24 at 1:10 p.m., nursing assistant (NA)-C indicated that they believe they have one resident that smokes residing in the facility. NA-C indicated R189 was told to either smoke far away from the building or there is a back door with a table that R189 was allowed to sit at. NA-C indicated the facility's a tobacco free facility and residents should not be smoking. NA-C stated they have not observed R189 smoking but "it is known that he goes and smokes" as he goes outside and comes in and you can smell it. NA-C indicated they have not observed burn holes in R189 clothes and indicated R189 was "pretty much independent.". On 12/12/24 at 9:18 a.m., business office coordinator (BOC)-A stated the facility typically doesn't have residents who smoke. BOC-A stated she would tell the social worker and director of nursing (DON) if there was a resident who was smoking. On 12/12/24 at 9:27 a.m., registered nurse (RN)-A indicated the facility was a tobacco free campus. RN-A indicated if a resident smokes, their family can come and take them out to go smoke or if there was a providers order or	F 655		

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F 655	Continued From page 17 physical therapy would write an order that they could leave the facility grounds. RN-A indicated the admission assessment asked about current tobacco use. RN-A stated it would be on the care plan if a resident was a known smoker. RN-A indicated if a resident was identified as a smoker, we let the social worker know right away for follow up. On 12/12/24 at 10:08 a.m., NA-D stated they were unsure of what the actual policy was if a resident was a smoker as when they first started residents were able to smoke in the parking lot, but they were unsure if they still could. NA-D stated R189 smokes and verified they have witnessed R189 go outside to smoke since admission. NA-D stated R189 will usually let staff know he was going outside to smoke but would go out independently. NA-D stated they have not seen any burn holes in R189's clothes or any signs on burns on his fingers. On 12/12/24 at 10:14 a.m., RN-B indicated the facility was smoke free facility. RN-B stated, "we usually don't take smokers, or they are on the patch for the time being." RN-B verified R189 currently smokes. RN-B stated they were aware R189 was a smoker as when R189 would visit other residents (prior to R189's admission), R189 would go outside and smoke. RN-B stated R189 had asked about going outside to smoke and RN-B stated she referred him to talk to staff in the office. RN-B verified no additional smoking assessments had been completed for R189 and verified no smoking cessation had been ordered. On 12/12/24 at 12:18 p.m., licensed social worker (LSW)-A indicated the facility is a non-smoking facility. LSW-A stated residents can not smoke on	F 655		

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F 655	Continued From page 18 our grounds so technically they can go outside the grounds, then we would have to go with them, so we don't allow that. LSW-A verified they knew R189 smoked prior to admitting to the facility. LSW-A stated she talked to R189 on 12/11/24 and inquired about a nicotine patch (4 days after admission) and verified no documentation of this. LSW-A verified R189's tobacco use was added to the care plan on 12/20/24 (3 days after admission) and after it was known R189 was smoking on outside on facility grounds. On 12/12/24 at 12:14 p.m., interim DON stated the facility's a non-smoking facility. DON verified additional assessment needs to be completed for identified smokers along with being care planned. DON verified she added tobacco use to R189 care plan on 12/10/24 (3 days after admission), the day she spoke with him. DON stated it would be expectation that tobacco use be identified on the care plan as soon as it was identified. On 12/12/24 at 2:40 p.m., RN-C stated the baseline care plans are the building blocks for the comprehensive care plans. RN-C verified there are not two separate care plans. RN-C verified if you pull up the care plan in the electronic medical record (EMR), the dates on the care plan are indicated and that is both the baseline and comprehensive care plan. On 12/12/24 at 2:04 p.m., administrator stated the facility's non-smoking facility and residents are told this prior to admission. Administrator indicated DON spoke with R189 about not being allowed to smoke on facility grounds. A facility policy titled Care Plan, reviewed/revised 12/2/24, indicated "a baseline care plan will be	F 655		

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F 655	Continued From page 19 developed upon admission according to federal and state regulations." A facility policy titled Smoking and Tobacco Use, reviewed/revised 11/24/24, indicated "Upon admission, all residents/clients who smoke or use tobacco products will be assessed dousing the Tobacco Use Assessment. Assessments also will be administered if a resident/client has a change in cognitive ability, judgement, manual dexterity and/or mobility. Care plan will be updated as needed."	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure routine personal care (i.e., bathing, nail care) were provided for 1 of 3 residents (R11) reviewed for activities of daily living (ADL's). Findings include: R11's admission Minimum Data Set (MDS) assessment, dated 9/11/24, indicated R11 had intact cognition with no hallucinations or delusions, no behaviors or no rejection of care. MDS assessment indicated R11 required maximal staff assistance for bathing and moderate assistance with personal hygiene. Diagnoses included: diabetes (disease that results in too much sugar in the blood), Alzheimer's disease (progressive disease that	F 677	1)R11 nails were trimmed on 12/12/24. spouge bath was given 12/13/24, and Whirlpool bath was given on 12/16/24. 2)All residents in the facility have the potential to be affected. A review of resident's nails and baths were reviewed on 12/20/24. Those found to be affected will have bath and nail care completed by 1/13/25. 3)To ensure systemic changes are sustained all nursing staff will be educated on the facility policy Activities of Daily Living. by 1/13/2025 by the DON or designee. 4)Audits will be conducted on 5 random residents by DON or designee for weekly bathing and nail care weekly x4. Results will be brought to QAPI for further	1/13/25

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F 677	Continued From page 20 affects memory and other mental functions), and epilepsy (abnormal electrical brain activity that causes seizures). R11's care plan, printed 12/12/24, identified R11 "has an ADL [activity of daily living] self-care performance deficit" with the following interventions: -"BATHING: Resident requires 1 staff for bathing. Prefers two baths/showers per week. -ORAL CARE STRENGTH: Resident is able to brush own teeth after set up. -TOILET USE: Resident requires 1 staff assist. -DRESSING: Resident requires 1 staff with LBD [lower body dressing]. Supervision for UBD [upper body dressing]." Furthermore, R11's care plan indicated R11 "has potential for impairment to skin integrity with the following intervention: -"Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short." R11's care plan lacked identification of level of assistance needed for nail care and what staff was responsible for nail care. R11's Kardex, printed 12/12/24, indicated the following: -"Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. -Bathing: Monday & Friday Evening -BATHING: Resident requires 1 staff assist for bathing. Prefers two baths/showers per week." R11's Kardex lacked identification of level of assistance needed for nail care and who was responsible for nail care. R11's Point of Care (POC) questionnaire for task	F 677	evaluation. 5)Compliance by 1/13/25	

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F 677	Continued From page 21 of bathing for type of bath that occurred by marking designated answer with a checkmark: -12/6/24: did not occur -12/2/24: shower R11's progress notes, dated 11/12/24 to 12/11/24 were reviewed. Progress notes lacked evidence of R11 refusing showers, staff assistance with ADLs or nail trimming. Furthermore, lacked documentation of staff offering an additional showers/bed bath/partial bath since last documented shower on 12/2/24 (10 days ago). During an interview on 12/10/24 at 9:54 a.m., R11 was observed seated in his wheelchair. R11's fingernails were observed to be approximately half inch long with some sharp edges with dark colored debris underneath them. R11 stated he would like assistance trimming his nails as he doesn't have a nail clipper, doesn't like his nails that long and stated no staff has offered to assist him. R11 stated that it was his preference to have 2 baths per week and "I haven't had a bath in at least 4 weeks." R11 stated doesn't understand why he is not getting 2 showers or baths a week. R11 stated, "my nails are really long." On 12/11/24 at 11:56 a.m., R11 was observed sitting in his room watching tv. R11 stated he has not been offered a shower or a bath and his nails continue to appear as they did yesterday. On 12/11/24 at 2:55 p.m., nursing assistant (NA)-C went and observed R11's fingernails and described them as "really, really long and need to be cut.". NA-C indicated staff assist resident with trimming nails. NA-C stated they do not document nail care in the electronic medical record (EMR) or on paper charts. NA-C indicated nail care	F 677		

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F 677	Continued From page 22	F 677		

should be offered with showers and when needed.

On 12/12/24 at 10:01 a.m., NA-D verified that nail care should be done with showers. NA-D verified that showers/baths are documented in POC (part of the EMR). NA-D verified there is no specific area to indicate when nail care was done. NA-D stated nurses provide nail care to residents that are diabetic and typically that is done on shower days. At 10:11 a.m., NA-D observed R11's fingernails and stated, "they are fairly long and chipped." While NA-D was observing R11's nail, R11 stated, "they are way too long."

On 12/12/24 at 10:21 a.m., registered nurse (RN)-B stated showers needed to be done at least once a week, but some residents had a preference of twice a week. RN-B stated if a resident refuses a shower, the nursing assistants will notify nursing and a progress note will be put in. RN-B verified R11 preference was twice a week and verified last documented shower was 12/2/24. RN-B verified no progress about shower refusals. RN-B verified a skin assessment was done on 12/9/24 and verified a skin assessment is completed whether a shower or not a shower is completed. RN-B stated the skin assessment does not include nail care documentation, but nursing should be providing nail care for R11 due to being diabetic. RN-B observed R11's nails and stated, "they are long, longer than regular nails should be." RN-B stated they were going to trim them as R11 asked RN-B to cut them. RN-B stated they should probably assist R11 trim their nails or at least supervise them to see if they can do it.

On 12/12/24 at 12:11 p.m., interim director of

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F 677	Continued From page 23 nursing (DON) stated R11 showers are offered twice a week and should be completed at minimum weekly unless refused. DON indicated refusals should be documented. DON verified last documented shower was 12/2/24 and that was not within needed timeline. DON verified nursing assistants should be doing nail care on bath days and as needed unless a resident diabetic then it would be done by nursing unless they are followed by podiatry. A facility policy titled Activities of Daily Living, reviewed/revised 12/4/23, indicated the purpose "to provide resident with appropriate treatment and services to maintain or improve abilities in activities of daily living for the well-being of mind, body and soul." Furthermore, clarifies that "ADLs are those necessary tasks conducted in the normal course of a resident's daily life, Included in these are the following: General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, applying makeup, skin, nails and oral care."	F 677		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the	F 685		1/13/25

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F 685	Continued From page 24 provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure vision needs were met for 1 of 1 residents (R31) reviewed for missing eye glasses. Findings include: R31's quarterly Minimum Data Set (MDS) dated 10/10/24, indicated R31 was diagnosed with dementia and required set-up help with dressing. The MDS indicated R31 had adequate vision and used corrective lenses. R31's admission assessment dated 1/25/24, indicated R31 had adequate ability to see in "adequate light (with glasses or other visual appliances)" and utilized corrective lenses. R31's care plan dated 2/22/24, indicated R31 had impaired cognition, impaired decision making, short-term memory loss, and scored an 8/30 on the Saint Louis University Status Examination (SLUMS, test to determine neurocognitive disorder/dementia) indicating dementia. R31's care plan indicated she needed the assistance of one person for dressing and grooming and had a history of falls. The care plan did not include R31's need for corrective lenses but did include a picture of R31 wearing eye glasses. R31's Kardex dated 12/10/24, was reviewed and did not include R31's need for corrective lenses. R31's medical record was reviewed and did not include information regarding R31's missing glasses or what interventions were placed	F 685	1)R31 representive was updated of glasses being misplaced on 12/13/2024. Representative will order new glasses for resident. Representative also schedules all optometry appointments for resident. R31 care plan 12/12/24 was updated to include the use of glasses for vision. 2)All residents who have visions impairment have the potential to be affected by the deficient practice. All resident□s who wear glasses were reviewed and care plans updated on 12/17/24. All resident glasses were present with the residents. On 12/20/2024 in house senior services was contacted to initiate contract for inhouse optomology. 3)To systemic changes are sustained, all nursing staff will be educated on the facility poicly of Eye Care-Glasses". Education will be given by DON or designee by 1/13/2025. 4)To ensure compliance, audits will be conducted on 5 random residents who wear glasses weekly x4 . Results will be brought to QAPI for further recommendations. 5) Compliance date: 1/13/2025	

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F 685	Continued From page 25 regarding her missing glasses. During an interview on 12/10/24 at 10:27 a.m., R31 stated she thought she lost her glasses a couple months ago and no one had offered to help her get new ones, but she did not recall which staff member she told they were missing. During an interview on 12/10/24 at 2:15 p.m., with registered nurse (RN)-A and nursing assistant (NA)-B, NA-B stated she wasn't sure if R31 wore glasses. RN-B stated he did not think R31 wore glasses as he did not find this information in the care plan. On 12/11/24 at 11:38 a.m., a call was attempted to R31's resident representative (FM)-C, a message was left, and no return call was received. During an interview on 12/12/24 at 10:58 a.m., NA-A stated she worked with R31 frequently and the last time she saw R31 wearing her glasses was three weeks ago, but she isn't sure what happened to them. NA-A stated she had not reported the missing glasses to the nurse on duty, director of nursing (DON), or other management staff and was not sure if anyone else had. NA-A stated R31 was "confused" so staff had to help her keep track of her clothing and belongs. During an interview on 12/12/24 at 9:31 a.m., the director of nursing (DON) stated R31 did wear glasses, but she had not been informed they were missing. The DON stated she would have expected nursing staff to notify her when they noticed the glasses were missing so they could notify the resident representative and get her	F 685		

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F 685	Continued From page 26 glasses replaced. At 1:33 p.m., the DON stated R31 did not have any appointment with an eye doctor set up currently and they had looked for her glasses but had not been able to find them. The facility's Eye Care policy dated 10/30/24, indicate the location would assist the resident in making appointments for vision treatment if necessary and refusals would be documented.	F 685		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with repositioning for 1 of 1 residents (R22) with a history of pressure ulcers. Findings include: R22's significant change Minimum Data Set (MDS) dated 11/5/24, indicated R22 had severely impaired cognition and was diagnosed with	F 686	1)R22 Care plan and orders were reviewed. Nursing staff were re-educated on repositioning R22. 2)All residents have the potential to be affected by the deficient practice. Specifically, residents with pressure ulcers and all residents with a Braden scale indicating High risk for pressure ulcers. have the potential to be affected. All residents with pressure ulcers were	1/13/25

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F 686	Continued From page 27 kidney disease, diabetes, and dementia. The MDS indicated R22 was dependent on staff for bed mobility and was receiving hospice care. The MDS indicated R22 was at risk of developing pressure ulcers. R22's provider progress note dated 11/26/24, indicated R22 had a pressure injury on her right shoulder, impaired skin integrity, limited mobility, and muscle weakness. The note indicated R22 was predisposed to pressure injuries due to weakness and inability to reposition herself. The provider encouraged staff to "offload and reposition [R22] as much as possible." R22's Order Summary Report dated 12/5/24, indicated nursing staff were to turn and reposition R22 every two to three hours and document all refusals in the progress notes. R22's progress notes were reviewed and lacked evidence indicating R22 refused repositioning on 12/11/24. During observation on 12/11/24 at 9:46 a.m., R22 was observed in a left-lying position in bed. During an observation and interview dated 12/11/24 at 1:48 p.m., R22 was observed in a left-lying position in bed. Registered nurse (RN)-D stated he was unsure when the last time R22 was turned as her aide, nursing assistant (NA)-C, oversaw ensuring R22 was repositioned. RN-D stated R22 was supposed to be repositioned every two hours so he would turn her now. R22 confirmed he had not assisted R22 in repositioning during the shift until this time. During an interview on 12/11/24 at 2:36 p.m.,	F 686	reviewed on 12/20/2024. No issues were identified. 3)To ensure systemic changes are sustained, all nursing staff will be re-educated on the facility policy Skin Assessment and Pressure Ulcer Prevention and Positioning by 1/13/2025. 4)To ensure compliance, audits will be conducted on R22 and 2 other random residents with pressure ulcers or high risk for pressure ulcers by the DON or designee weekly x4. Results will be brought to QAPI for further recommendations. 5)Compliance date: 1/13/2025	

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F 686	Continued From page 28 NA-C stated she oversaw assisting R22 with repositioning and it was supposed to be completed every two hours. NA-C stated the last time she had repositioned R22 was around 6:30 a.m. and confirmed that no one had assisted R22 with repositioning until RN-D had at 1:48 p.m. NA-C stated she had planned to turn R22 again after breakfast but had gotten too busy. During an interview on 12/12/24 at 9:43 a.m., the director of nursing (DON) stated it was important for staff to reposition R22 every two to three hours especially given her pressure ulcer history to prevent new injuries or worsening of the pressure injury she already had. The Facility Skin Assessment Pressure Ulcer Prevention and Documentation Requirements-Rehab/Skilled policy dated 4/26/24, indicated residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches.	F 686		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		1/13/25

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F 758	Continued From page 29 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate side effect monitoring of psychotropic medication	F 758	1)On 12/23/25 R26 orders were added for psychotropic side effect monitoring, and care plan update for non-	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 30 consumption for 1 of 5 residents (R26) reviewed for unnecessary medication use. Findings include: R26's admission Minimum Data Set (MDS) dated 9/26/24, indicated R26 was cognitively intact, needed setup for oral hygiene and eating, needed moderate assistance with upper body dressing and was dependent with bathing, lower body dressing, personal hygiene, and toileting. The MDS included diagnoses of fractures and other multiple traumas, atrial fibrillation (irregular heart rhythm that can lead to blood clots in the heart) , hypertension (high blood pressure), renal insufficiency (poor function of the kidneys), hyperlipidemia (high levels of fat particles in the blood), thyroid disorder (thyroid gland dysfunction), arthritis (swelling and tenderness in one or more joints), depression, and glaucoma (a condition that damages the optic nerve that causes vision loss and blindness). R26's Clinical Orders report dated 12/10/24, identified R26 had physician orders for several psychotropic medications including the following: - trazadone HCL (medication to treat major depressive disorder) 25 milligrams (mg) tablet: take 25 mg by mouth once a day for insomnia with a start day of 9/20/24. - Cymbalta delayed release (medication to treat major depressive disorder) particles 60 mg capsules: take 2 capsules every morning for anxiety with a start date of 9/21/24. - bupropion HCL extended release (medication to treat depression) oral tablet: take 300 mg every morning for anxiety with a start date of 9/21/24. - aripiprazole (medication to treat depression) oral tablet: take 20 mg at bedtime for depression with	F 758	pharmacological interventions for sleep. 2)All residents receiving psychotropic medications have the potential to be affected. All residents taking psychotropics will be reviewed orders updated for psychotropic side effect monitoring by 1/13/25. All residents taking hypnotics will have nonpharmacological interventions for sleep added to their care plan by 1/13/25. 3)To ensure systemic changes are sustained. All nurses will be educated by the DON or designee on the facility policy Psychotropic medications by 1/13/25. 4)Audits will be conducted by the DON or designee on 5 random residents. Residents who are newly admitted or have orders for psychotropic medications weekly x4 to ensure side effect monitoring is in place and care plans are updated for nonpharmacological interventions for sleep. Results will be brought to QAPI for further recommendations. 5)Compliance date: 1/13/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING _____ B. WING _____	C 12/12/2024

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GOOD SAMARITAN SOCIETY INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 758	Continued From page 31 a start date of 9/20/24. R26's clinical orders report dated 12/10/24 had boxed warnings for trazadone, bupropion, aripiprazole, and Cymbalta as follow: Warning: suicidal thoughts and behaviors. Closely monitor all antidepressant treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. R26's care plan printed on 12/11/24, indicated R26 was on antidepressant medication therapy related to depression, anxiety, and insomnia. Interventions listed included: - Monitor resident condition based on clinical practice guidelines or clinical standards of practice related to use of trazadone, duloxetine [Cymbalta], bupropion, aripiprazole. - Warnings #1: Refer to boxed warnings in the orders or eMar [electronic MAR]. R26's care plan lacked evidence of monitoring of side effects, and/or non-pharmacological interventions attempted in the past or present and effectiveness. It also lacked non-pharmacological interventions for sleep. R26's medication administration record (MAR) for November and December 2024, printed on 12/11/24, lacked evidence of monitoring side effects of psychotropic medications, non-pharmacological interventions for sleep or behaviors or indication of target behaviors. During interview on 12/11/24 at 11:48 a.m. registered nurse (RN)-D stated, residents taking antidepressant needed to be monitored for side effects (SE), document their behaviors and vital signs.	F 758		

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F 758	Continued From page 32 During interview on 12/11/24 at 11:55 a.m. RN-A stated, when residents take psychotropic medications including antidepressants, antianxiety and antipsychotics nurses needed to monitor their mood, behaviors, refusal of cares, restlessness. RN-A indicated the monitoring was documented in the MAR. RN-A stated interventions to address behaviors, anxiety, etc. needed to be in place to properly care for their residents. During interview on 12/11/24 at 1:59 p.m. pharmacist consultant (PC) stated, usually residents taking antidepressant medications needed to be monitored for confusion, sedation, and cognitive changes. PC stated behaviors needed to be monitored using some kind of tracking form to measure the effectiveness of the medications. During interview on 12/11/24 at 2:13 p.m. director of nursing (DON) verified there was no monitoring or documentation of behaviors, interventions or side effects related to R26's antidepressants medications. DON stated, nursing needed to monitor and document behaviors and side effects. DON also stated if a resident was taking a medication for insomnia, nursing should monitor and document the resident's hours of sleep. DON stated the documentation of behaviors would assure gradual reductions of psychotropic medications would be accurately done. Facility's policy titled Psychotropic Medications-Rehab/Skilled dated 12/6/23 indicated a Psychotropic medication referred to any drug that affects brain activities associated	F 758		

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F 758	Continued From page 33 with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: anti-psychotics; antidepressants; anti-anxiety; and hypnotics. Policy indicated throughout the administration of the psychotropic medications; the following must be completed: a. Mood and behavior documentation must continue to monitor the effect the medication has on the behavior. b. Monitor side effects of the medication. If a side effect occurs or worsening of a known side effect is noted, the nurse will make a note in Point Click Care (PCC) and notify the physician and family/legal representative of this change in condition.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		1/13/25

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F 812	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure final cooking temperatures were checked or obtained in a manner to reduce the risk of cross-contamination between food items prepared in the main production kitchen. This had potential to affect all 36 residents who were served the meal. Findings include: On 12/10/24 at 11:36 a.m., food production in the main kitchen was observed with cook (CK)-A present. CK-A placed a metallic tray filled with breadsticks into the oven and pulled out a pan which had two, foil pans on top with lasagna in them. CK-A used a spike-style thermometer to pierce the seal over the lasagna and obtain a temperature which read, "182 [F]." CK-A then turned and stated aloud to the food and nutrition service manager (FNM) they were looking for a wipe to clean the probe of the thermometer. FNM left the kitchen and returned with a white-colored box labeled, "Ecolab Probe Wipes," and placed them on the elevated counter. The counter space contained another box of these wipes hidden amongst some spices and paper, along with several loose ones in a hard-plastic tray seated on the same counter surface. CK-A removed a wipe from the obtained box and used it to clean the thermometer spike before re-sheathing it and placing it back on the counter for future use. The box of wipes FNM obtained, along with the other wipes present, were reviewed. The boxes and individual wipes both contained the following items printed on them, "[LOT] 08302020," and, "[Hour-glass symbol] 08292023."	F 812	1)All expired probe wipes were removed from the kitchen on 12/12/24. Education was given to CK-A on 12/10/24 on checking the expiration dates in probe wipes. CK-A was educated on 12/10/24 on proper sanitizing of probe in-between different foods. CK-A was educated on using food safe sanitizing items only to clean probes on 12/10/24. 2)All residents have the potential to be affected by this deficient practice. 3)To ensure systemic changes are sustained. All kitchen staff will be educated on the facility policy Food temperature monitoring by 1/13/2025 4)Audits will be completed by the Dietary manager or designee of expiration dates of food safe sanitizer and proper sanitizing of probes between different foods weekly x4. Results will be brought to QAPI for further recommendations. 5)Compliance date 1/13/25.	

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F 812	Continued From page 35 At 11:50 a.m., CK-A removed the breadsticks from the oven. CK-A then picked up another spike-style thermometer and cleaned the probe using the same wipes available before replacing the sheath of the probe. CK-A was not observed spiking any food using this thermometer despite cleaning it using the wipes. CK-A then placed the thermometer back on the counter before moving to the opposite side and working on shredded carrots which were in another metallic pan. At 11:59 a.m., CK-A loaded the prepared lasagna, carrots and breadsticks onto a mobile cart and brought them out to the dining room to place into an activated steam table. CK-A was questioned on final cooking temperatures of the items and expressed they hadn't obtained them yet. CK-A returned to the kitchen and obtained one of the spike-style thermometers observed just prior along with a torn-open Ecolab wipe. CK-A then placed the spike of the thermometers into the lasagna, removed it, and then immediately inserted it into the carrots. CK-A did not clean the spike between food items despite having the wipe in their hand. CK-A was questioned on cleaning the spike and stated it should be cleaned between each food item to prevent "cross contamination" of the items. CK-A verified the wipes located in the kitchen were what they obtained prior and, upon the surveyor request, checked the boxes and wipes. CK-A verified the dates on the boxes and stated they had never been told to check them for an expiration date, rather just the packaging of them should be intact if using them. CK-A then stated they had, at times, used another type of wipe to clean the thermometer spike and showed the surveyor a plastic container of wipes. These were labeled, "Purell Hand Sanitizing Wipes," and CK-A reiterated using them on the spike, too, adding	F 812		

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F 812	Continued From page 36 aloud, "Yea, sometimes." CK-A stated they were unsure if the Purell wipes' were safe for food items or, as a result, potential human consumption of the residue. CK-A then began to plate and serve the prepared meal to the residents' seated within the dining room. The following day, on 12/11/24 at 1:19 p.m., FNM was interviewed. FNM stated the Ecolab wipes were expired and they had just ordered more adding, "I didn't notice that [expired]." FNM stated other products could be used in the meantime which were "food safe" to sanitize the thermometer spike. FNM stated they were unaware CK-A had been using Purell hand sanitizing wipes to clean the spike and expressed they had "corrected him right away" to not use them further. FNM verified wipes used to clean the thermometer spike should be current adding, "You always want to use things that are not expired." FNM stated doing such was, "A huge thing for food service." FNM stated checking the wipes being used for expiration was not on a formal kitchen audit list but expressed aloud, "We should be checking [them]." When interviewed on 12/12/24 at 10:22 a.m., registered dietician (RD)-A stated they were currently helping to cover the care center' campus describing their help as "PRN as they need me." RD-A stated they had not been physically onsite to the campus "since sometime last year," but expressed thermometer probe wipes, such as the Ecolab ones observed, were used at their campus too, however, they were unsure if they were the same brand or not. RD-A stated they couldn't recall what the printed dates meant on the packaging of the wipes adding they would have to consult with the food service	F 812		

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F 812	Continued From page 37 manager about it as they dealt more with food safety. However, RD-A stated from their understanding the wipes would likely be "less effective after that date [expiration] and you shouldn't use them." Further, RD-A verified the thermometer spike should be cleaned between food items adding such was important "so there's no cross contamination or allergen spreading." On 12/12/24 at 10:24 a.m., the Ecolab representative (ERP) was contacted. A return call was received on 12/12/24 at 11:12 a.m., and ERP was interviewed. ERP verified they were the assigned representative for the care center and expressed they had last visited with FNM "last week" about other items. ERP stated they were unsure the exact meaning of the symbols on the packaging adding aloud, "I would have to look into that." ERP stated the care center was their only account which used them and expressed they had just told FNM a "better work around" would likely be using a food-safe contact cleaning solution which they already had on-hand. ERP explained the wipes were developed by another division of the company and reiterated he was unsure of the symbol or dates' meaning but expressed with an hour-glass present next to the a date it was "probably true" they had expired. ERP stated their 'general guidance' was their products were expired or shouldn't be used "after a year" adding again such was "a general guideline." A facility' provided Food Temperature Monitoring policy, dated 12/2023, identified a procedure to check final cooking temperatures of prepared items. This included inserting the thermometer into the center, thickest part of the food for at least 15 seconds and, "The thermometer is	F 812		

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F 812	Continued From page 38 cleaned and sanitized after testing each food item (See Food Thermometers)." A provided Food Thermometers policy, dated 12/2023, identified the tool was a critical device to effective monitoring of food temperature adding, "Thermometer probes are cleaned and sanitized on a regular basis to limit contamination and prevent foodborne illness." The policy continued with a section labeled, "Sanitizing Thermometers," which directed they should be sanitized according to manufacturer guidelines and after, "Between taking temperatures of different foods/fluids." Further, the policy directed either an alcohol swab or food contact approved sanitizing solution should be used according to the manufacturer's directions.	F 812		

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	245285	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/11/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on December 11, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society - Inver Grove Heights, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/24/2024

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Good Samaritan Society - 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1981 and 1983, additions were constructed to the North Wing that was determined to be of Type II(000) construction. In 1999 an addition was added to the South Wing that was determined to be of	K 000		

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K 000	Continued From page 2 Type II (000) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 46 beds and had a census of 37 at the time of the survey.	K 000		
K 345 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 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 by: Based on a review of available documentation, and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 33.2.3.4.1, 9.6, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, 14.4.5, 14.4.5.3. This deficient finding could have a widespread impact on the residents within the facility.	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	1/13/25

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K 345	Continued From page 3 Findings include: On 12/11/2024 between 8:00 AM and 10:00 AM, it was revealed during a review of available documentation that a detailed sensitivity report was not available for review. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	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. 1. Smoke detector sensitivity testing will be scheduled by 12/30/2024. 2. All residents residing in the facility have the potential to be affected by this deficient practice. 3. Environmental Services Director received education on 12/23/2024 on smoke detector sensitivity testing requirements.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		1/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/11/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY INVER GROVE HEIGHTS	**1301 50TH STREET EAST** **INVER GROVE HEIGHTS, MN 55077**

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K 353	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. This deficient finding could a widespread impact on the residents within the facility. Findings include: On 12/11/2024 between 8:00 AM and 10:00 AM, it was revealed by observation that storage materials had been placed within 18" of the sprinkler system in the cooler within the Kitchen. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	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. 1.All items within 18 inches of Sprinkler Head located in walk in cooler were removed 12/11/24 during fire marshal inspection. 2. All residents residing in the facility have the potential to be affected by this deficient practice. 3. To ensure systemic changes are sustained, environmental Services Director received education on 12/23/24 regarding the importance of maintaining the 18in around Sprinkler head. All dietary employees will be trained by 1/13/25 of the importance of maintaining 18 inches around sprinkler heads. 4. Audits will be completed by the environmental services director or designee to ensure 18 inches around sprinkler heads is maintained. Audits will be done weekly x4 and findings brought to	

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K 353	Continued From page 5	K 353	QAPI for further recommendations.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/11/2024, between 8:00 AM and 10:00 AM, it was revealed by observation that the electrical panel located in the Laundry Area was not locked. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	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. 1. A lock was placed on the electrical panel in the laundry room on 12/20/24. 2. All residents residing in the facility have	1/13/25

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K 511	Continued From page 6	K 511	the potential to be affected by this deficient practice. 3.Environmental Services Director received education on 12/23/24 regarding the importance of maintaining locks on electrical panels. 4. Administrator or Designee will audit weekly x4 to ensure electrical panel remains locked. Audit finding will be brought to QAPI for further recommendations.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 521	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,	1/13/25

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K 521	Continued From page 7 On 12/11/2024 between 8:00 AM and 10:00 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the dampers in the facility had been inspected within four years. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. All dampers re-inspected on 10/23/23 and documentation has been revised to list locations of each damper. 2. All residents residing in the facility have the potential to be affected by this deficient practice. 3. Environmental Services Director received education on 12/23/24 regarding the importance of fire damper testing and documentation showing location of each damper.	
K 712 SS=F	Fire Drills 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 a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This	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	1/13/25

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K 712	Continued From page 8 deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/11/2024, between 8:00 AM and 10:00 AM, it was revealed by a review of available documentation that a fire drills was not completed in November of 2024 for the 2nd shift. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	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. 1.Missed quarterly fire drill will be conducted 12/30/24. 2.All residents residing in the facility have the potential to be affected by this deficient practice. 3.Environmental Services Director received education on 12/23/24 regarding quarterly fire drill requirements. 4.Administrator or Designee will conduct monthly audits x 3 to ensure fire drills are being conducted per code. Audit findings will be brought to QAPI for further recommendations.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 29, 2025

Administrator
Good Samaritan Society Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

RE: CCN: 245285
Cycle Start Date: December 12, 2024

Dear Administrator:

On January 17, 2025, 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us