DEPARTMENT OF HEALTH			D CERTIFIC	CATION A	CENTERS FOR MEI	DICARE & MEDIO	ID: B617
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00085
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245558		3. NAME AND AL (L3) GOOD SAM			INDOM	 TYPE OF ACTION Initial 	DN: <u>7</u> (L8) 2. Recertification
2. STATE VENDOR OR MEDICAID N (L2) 677840200	0.	(L4) 705 SIXTH (L5) WINDOM , 1			(L6) 56101	 Termination Validation 	 CHOW Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9I	VNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Afte	9. Other r Complaint
6.IATEIOFISURVEY 7/18/2016 I. ACCREIITATIONISTATUS 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END 12/31	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):		Compliance		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SP	6. Scope of S 7. Medical D	ervices Limit irector
12.Total Facility Beds 13.Total Certified Beds	78 (L18)78 (L17)	B.IIINotIinIComp	^		5. Life Safety Code	9. Beds/Room (L12)	1
14. LTC CERTIFIED BED BREAKDOW	N	requirements	una or rippilea (varvers.	* Code: A* 15. FACILITY MEETS	(112)	
18 SNF 18/19 SNF 78	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMAR 17. SURVEYOR SIGNATURE	XKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):	18. STATE SURVEY AGENCY	7 APPROVAL	Date:
Gloria Derfus. Unit Supervisor		7	7/28/2016	(L19)	K <u>amala Fiske-Downing, Hea</u>	Ith Program Represe	entative 7/28/2016 (L20)
PART	TII - TO BE	COMPLETED I	BY HCFA RE	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	7/28/2016 (L20)
 DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Part 2. Facility is not Eligible 			IPLIANCE WITH ITS ACT:	H CIVIL	 Statement of Fina Ownership/Contr- Both of the Above 	ol Interest Disclosure Stm	
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION		(L30)
OF PARTICIPATION 05/01/1991	BEGINNINC	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER	ler Status Change
(L27)	B. Rescind St	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00140					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245558

July 28, 2016

Ms. Nancy Wepplo, Administrator Good Samaritan Society - Windom 705 Sixth Street Windom, MN 56101

Dear Ms. Wepplo:

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

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

Effective the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kumala Fiske Downing

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



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 28, 2016

Ms. Nancy Wepplo, Administrator Good Samaritan Society - Windom 705 Sixth Street Windom, MN 56101

RE: Project Number S5558024 & H5558011

Dear Ms. Wepplo:

On June 17, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 3, 2016 that included an investigation of complaint number H5558011. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 18, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 3, 2016, effective July 11, 2016 and therefore remedies outlined in our letter to you dated June 17, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REVIS	IT
	B. Wing	Y	(2	7/18/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY	- WINDOM	705 SIXTH STREET			
		WINDOM, MN 56101			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix F024	1	Correction	ID Prefix	F0246		Correction	ID Prefix	F0248		Correction
Reg. #	5(a)	Completed	Reg. #	483.15	(e)(1)	Completed	Reg. #	483.15(f)(1)		Completed
LSC		07/11/2016	LSC			07/11/2016	LSC			07/11/2016
ID Prefix F028	2	Correction	ID Prefix	F0373		Correction	ID Prefix	F0431		Correction
483.20 Reg. #	0(k)(3)(ii)	Completed	Reg. #	483.35	(h)	Completed	Reg. #	483.60(b), (d), (e)		Completed
LSC		07/11/2016	LSC			07/11/2016	LSC			07/11/2016
ID Prefix F046	3	Correction	ID Prefix	F0465		Correction	ID Prefix			Correction
483.70 Reg. #	D(f)	Completed	Reg. #	483.70	(h)	Completed	Reg. #			Completed
LSC		07/11/2016	LSC			07/11/2016	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEWED BY	Y 🔲 (IN	VIEWED BY ITIALS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
		D/kfd	7/28/201	6			18623			/2016
REVIEWED BY CMS RO		VIEWED BY ITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO 6/3/2016	SURVEY CO	MPLETED ON		CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?				s 🗌 no		

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF	REVISIT
	B. Wing	Y2	7/24/2016	6 _{Y3}
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY	- WINDOM	705 SIXTH STREET		
		WINDOM, MN 56101		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE		DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0025	06/29/2016	LSC	K0144	06/29/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
REVIEW STATE A		REVIEWED BY (INITIALS)	DATE	SIGNATUF	RE OF SURVEYOR		DATE	
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOW 6/1/2016		Y COMPLETED ON			DRRECTED DEFICIEN EIENCIES (CMS-2567)			s 🗌 no

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAII	D CERTIFIC	CATION A	AND TRANSMITTAL	ID: B617
	PART I -	TO BE COMPL	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00085
1. MEDICARE/MEDICAID PROVID NO.(L1) 245558	DER	3. NAME AND AD (L3) GOOD SAM			INDOM	 4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAIE (L2) 677840200	D NO.	(L4) 705 SIXTH S (L5) WINDOM, N			(L6) 56101	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 06/0.8. ACCREDITATION STATUS:	3/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 0 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited1 TJC2 AOA3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	' IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :		Program Re Compliance			2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12. Total Facility Beds	78 (L18)	1. Ad	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size
13.Total Certified Beds	78 (L17)	X B. Not in Com	pliance with Prog	gram	5. Life Safety Code	9. Beds/Room
			and/or Applied V		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
78	(1.20)	(1.12)	(1.42)			
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION 1	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Carrie Fuerle, HFF NF II</u>		0	7/01/2016	(L19) H	Kamala Fiske-Downing, Heal	th Program Representative 07/22/2016 (L20)
PA	RT II - TO BE	COMPLETED F	BY HCFA RE	EGIONAI	LOFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGIBID	LITY		IPLIANCE WITH	H CIVIL		icial Solvency (HCFA-2572)
1. Facility is Eligible to 1	Participate	RIGH	ITS ACT:		 Ownership/Contro Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	e (L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 05/01/1991	BEGINNING	G DATE	ENDING DA	ГЕ	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	-
25. LTC EXTENSION DATE:	27. ALTERNATI	VESANCTIONS	(L23)		03-Risk of Involuntary Terminatio	-
25. LIC EXTENSION DATE.		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APPE	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 17, 2016

Ms. Nancy Wepplo, Administrator Good Samaritan Society - Windom 705 Sixth Street Windom, Minnesota 56101

RE: Project Number S5558024 & H5558011

Dear Ms. Wepplo:

On June 3, 2016, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 3, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5558011 that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0970 Telephone: (651) 201-3792 Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 13, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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

Good Samaritan Society - Windom June 17, 2016 Page 4

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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by September 3, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions

Good Samaritan Society - Windom June 17, 2016 Page 5

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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Good Samaritan Society - Windom June 17, 2016 Page 6

> Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

ate Compton

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

		AND HUMAN SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1	<u> </u>	MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245558	B. WING		06/03/2016
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD SA	AMARITAN SOCIETY	- WINDOM		05 SIXTH STREET VINDOM, MN 56101	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENT	ſS	F 000		
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat	acceptable electronic POC, an			
	validate that substa	ur facility may be conducted to ntial compliance with the en attained in accordance with			
F 241 SS=E	and a complaint inv completed at the tir investigation of com substantiated during	cation survey was conducted restigation(s) was also ne of the standard survey. An pplaint H5558011 was not g this survey. AND RESPECT OF	F 241		7/11/16
	manner and in an e enhances each res	omote care for residents in a nvironment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observat review, the facility fa morning routines in residents (R21, R24 who were cognitive extensive assistant daily living (ADLs).	NT is not met as evidenced tion, interview and document ailed to provide rising and a dignified manner for 7 of 10 4, R34, R43, R50, R56, R65), ly impaired and required the to complete activities of In addition, the facility failed to		F-241 Corrected Date: July 11, 2016 It is the current policy and procedur GSS-Windom to respect all residen rights, including those regarding dig and preferences.	it jnity
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically Signed				06/27/2016

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.

PRINTED: 10/24/2016

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		0938-039 E SURVEY	
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	IPLETED	
		245558	B. WING		06/	03/2016	
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 241	Continued From pa	ae 1	F 2	41			
	provide care and servespectful manner for resident (R12) revises Findings include: R21's care plan data required extensive a directed staff to ass and personal hygien mechanical stand lim MDS dated 3/25/16 cognitively impaired. During an observate R21 was sitting in harea of the unit. She R24's annual MDS was moderately cog decreased ability to understand others. 3/17/16, indicated sorved the dressing, groot transfers using a m staff. During an observate R24 was dressed a difference of the context of the contex	ervices in a dignified and for 1 of 1 cognitively impaired ewed for dignity. The grad of the second		 The assessments and care R24, R34, R43, R50, R56 reviewed and updated by managers as needed to rechoice in their morning received and light states were elimited. All lists were elimited reside outside of the unit, extensive assistance are deficient practices. Their and care plans will be revupdated by the case man to reflect individual choiced routines, by July 11, 2016 R20□s care plan was revet to be appropriate by the constrained of the unit, extensive assistance are deficient practices. Their and care plans will be revupdated by the case man to reflect individual choiced routines, by July 11, 2016 R20□s care plan was revet to be appropriate by the constrained of the practice of the plans on July 1000 and the plans on July 2016 by the Director of N written and on-line material All nursing staff will be reprivate Director of Nursing on July 30, 2016, regarding reside 	5, and R65 will be the case eflect individual outines by July 1, nated. itively impaired, and require at risk for similar assessments riewed and lagers as needed e in their morning 5. riewed and found case manager. entia are at risk ces by this icated regarding ys to interact ntia, and une 6 and 17, ursing using ials. -educated by the ne 28, 29, and		
	was severely cognit plan dated 2/20/16,	S dated 4/20/16, indicated he tively impaired. R34's care indicated he required physical grooming and personal		preferences of residents regarding morning routine following the care plan ar interventions for persons An audit of the morning re random residents who ar	es, as well as ad therapeutic with dementia. outines of 2		

Facility ID: 00085

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 10/24/2016 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY IPLETED
		245558	B. WING		06/	03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	Continued From pa	age 2	F 241	1		
	R34 was ambulatin toward the shower During an interview nursing assistant (I R34 up every week R43's care plan day required assistance transferred using a MDS dated 4/1/16, cognitively impaired During an observat R43 was in bed. Sh on top of a lift sling R50's care plan day deficit related to we assist with dressing transfer using a tot	y on 6/3/16, at 9:12:10 a.m., NA)-M stated she had to wake a for his bath. ted 4/14/16 indicated she e of two staff for all ADL's and total body lift. R43's quarterly indicated she was severely		impaired, reside outside of the u require extensive assistance wil conducted by the Director of Nu designee, 3x/week for 2 weeks, 2x/week for 4 weeks, and then r x2. Audit reports will be reviewe QAPI committee with appropriat follow-up initiated.	l be rsing or then nonthly ed by the	
	During an observat R50 was up in her During an observat R50 was sitting in h front of the televisio During an interview stated she had to w dressed because s R56's care plan da	tion on 6/3/16, at 6:57 a.m., wheel chair and dressed. tion on 6/3/16, at 7:40 a.m., her wheel chair, sleeping in on. on 6/3/16, at 7:00 a.m., NA-O vake R50 up and get her he ate breakfast at 8:00 a.m. ted 3/20/14 indicated an ADL d directed staff to assist with all				

If continuation sheet Page 3 of 32

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NC (X3) DA	TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245558	B. WING _			/03/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 705 SIXTH STREET	Ξ	
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 241	Continued From pa dated 4/1/16, indica impairment.	ge 3 ted moderate cognitive	F 24	41		
	self-care deficit and with dressing, groor	ed 2/29/16, indicated an ADL I directed staff to assist her ning and transfers. R65's ated she was severely I.				
	document titled NO posted at the cente document indicated R56 620am, R20- 6	ion on 5/31/16, at 5:51 p.m., a C (overnight) gets up was r nurse's station. The I the following: "R21- 6 am, 640am and R34 7am. Two wo additional residents."				
	dated 6/3/16, listed marks next to their names. A review of	v document labeled, Center, ten residents with check names and six additional a facility document titled 11-7, In AM, and dated 5/23/16,				
	stated she gets resi if the call light was of She stated, "I don't get residents washe bed." NA-B further	on 6/3/16, at 6:13 a.m., NA-B idents up for the day based on going off and who gets a bath. like to disturb anyone, so I will ed, dressed, and leave them in stated the residents ate at a are a priority and then two				
	stated she worked t she had a list of six up in the morning. N them up to get then	on 6/3/16, at 6:45 a.m., NA-C the overnight shift. She stated residents that she had to get NA-C stated, "I have to wake n dressed and washed and in tarting at 5:00 a.m. "				

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COI	MPLETED
		245558	B. WING _		06	/03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 241	stated she worked had a list of resider morning. She state get up eight people stated they have to for the day. NA-N f people up to get th During an interview registered nurse (F people the night sh how many staff are letting residents sle RN-B stated she w residents up to get During an interview stated the list of wh who was awake. S night shift staff resi one with dressing a arrived to work at S unaware staff were them ready for the practice we encour During an interview director of nursing has a list of resider early. She stated th responsible for who between the nurse charge nurse they She stated if a resi staff may get them	y on 6/3/16, at 7:05 a.m., NA-N the night shift. She stated she nts she had to get up in the ed if there are two staff on they e starting around 5:00 a.m. She be ready before she leaves urther stated, "We wake em dressed." y on 6/3/16, at 7:09 a.m., RN)-B stated the number of hift gets up varies depending on e on. She stated staff should be eep unless they are a fall risk. vas not aware staff were waking them ready for the day. y on 6/3/16, at 7:17 a.m., RN-D no gets up early was based on he stated she tried to give the idents who require assist of and transfers. RN-D stated she 5:30 a.m., but she was e waking up residents to get day and stated, "It is not a	F 24			

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION		0938-039 E SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:				· · /	PLETED
		245558	B. WING			06/	03/2016
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			5 SIXTH STREET INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 241	Continued From pa	age 5	F 2	41			
	stated she typically every day. She stat so they can get to l	y on 6/3/16 at 9:12 a.m., NA-M woke up several residents ted she had to wake them up preakfast. She stated she had hould let residents sleep until get up.					
	3/30/12, with diagn	lentified an admission date of oses that included dementia, and delusional disorders.					
	behavior symptoms behavioral disturba E/B [evidenced by] refused meds or hi thoughts about bein [occasionally] holle staff's attention to b Interventions identi "Behavior #2- repe included "meet res unable to assist im note the exact time bathroom next. Ref	ted 4/22/16 indicated R12 "has s r/t [related to] dementia with ince and depressive disorder hx [history] of res [resident] des them d/t paranoid ng poisoned and she occ. rs out obscenities to summon be escorted to the bathroom." fied on the care plan under ated bathroom requests" ident's needs promptly. If mediately, hand her written that she will be assisted to the assure her often that she will n as possible if she is having					
	Assessment dated severe cognitive im	gnificant Change MDS 4/29/16, indicated R12 had pairment and was totally cility staff for personal cares ily living.					
	her wheelchair in th	9 p.m. R12 was observed in the hallway between the nurses hroom yelling "I have to pee"					

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	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION		. 0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				IPLETED
		245558	B. WING		06	/03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 241	door. Licensed prac stood over R12 in fr began to yell at R12 assistant (AA)-B "H need two people to have anyone else." past LPN-B and into grab out toward LPI resident "Don't you continued to try to g bathroom stating, "I go, I have to pee." I but I don't have any to "get help" and AA R12 then grabbed L began to yell in R12 ouch, ouch" while tr R12's grasp. Anothe directly toward R12 to R12 she was "he bathroom." R12 let calm and was assist was not observed to she would be assist LPN-B was interview regarding the incide LPN-B stated R12 k quickly and was gra hands." LPN-B state her." Interview with the m 6/2/16, at 12:00 p.m of behaviors and sta on a toileting plan a regarding what time	ge 6 heelchair into the bathroom cront of the bathroom door and 2 while pointing at an activity e can't use the machine, we use the machine and we don't R12 then attempted to get to the bathroom. R12 began to N-B. LPN-B yelled at the hit me, my dear." R12 get past LPN-B into the have to pee, that's where I LPN-B stated "I know [R12] help." LPN-B directed AA-B A-B left the memory care unit. .PN-B's arm and LPN-B directed AA-B beft the memory care unit. .PN-B's arm and LPN-B directed the unit, went and LPN-B and stated calmly re to help [R12] to the go of LPN-B's arm, appeared ted to the bathroom. LPN-B owrite R12 a note of when ted to the bathroom. . PN-B's arm and corred with R12. .Decame "very agitated, very abbing me by the wrists and ed "this happens a lot with	F 2	41		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION		TE SURVEY	
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CO	MPLETED	
		245558	B. WING		06/03/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 705 SIXTH STREET	E		
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 241	if R12 was being pl staff. RN-C indicat work with residents would not expect st demeaning manor.	rom R12 and reapproach later hysically aggressive towards ed staff have been trained to who have behaviors and taff to treat R12 in a	F 24	1			
	6/2/16, at 1:00 p.m. training on how to o dementia and beha she expected staff residents and act in	sing (DON) was interviewed on . and stated all staff receive care for residents with wiors. The DON further stated to follow the care plan for all a professional and en with residents who exhibit					
	Resident Dignity, da reviewed. The polic maintaining the dig	d Good Samaritan Society ated February 2013, was by indicated a purpose of nity of all residents and to ng and abiding by resident					
F 246 SS=D	483.15(e)(1) REAS OF NEEDS/PREFE	ONABLE ACCOMMODATION ERENCES	F 24	6		7/11/16	
	services in the facil accommodations o preferences, excep	right to reside and receive ity with reasonable f individual needs and t when the health or safety of her residents would be					
	This REQUIREME	NT is not met as evidenced					

Facility ID: 00085

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPI F		1	0938-039 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245558	B. WING _			06/03/2016	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		-	5 SIXTH STREET INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 246	Continued From pa	ge 8	F 24	46			
		ailed to ensure 1 of 1 resident			Corrected Date: July 11, 2016		
	(R49) who was identified at being at risk for falls had a call light within reach. Findings include:				It is the current policy and procedur GSS-Windom to assure each resid their call light within reach, while in	lent has	
	R49 was admitted to the facility 2/3/12, with admission diagnosis of heart failure, deep vein emboli (blood clot in legs), and hypertension per the Admission Face Sheet. R49 had moderately	o the facility 2/3/12 with			room.	liieii	
		s of heart failure, deep vein n legs), and hypertension per			The call light was secured within re R49 at the time of the survey obser		
	intact cognition, and R49 required exten- bed mobility, transfe	d did not exhibit any behaviors. sive assistance of two staff for ers, and toilet use. R49 was			All residents are at risk for this defipractice and will be audited via the schedule below.	cient	
	request. The Care I R49 was dependen able to call for assis undated Visual/Bed "Resident is able to	se of her call light upon Plan dated 3/17/16, identified t on staff for cares and was stance using the call light. The Iside Kardex report indicated call for assistance when in			All employees will be re-educated be Director of Nursing regarding resid- light placement and the importance securing the call light within reach of resident by July 11, 2016.	ent call e of	
	pain." On 6/1/16, at 9:03 a observed and interv not within reach. R4 wheelchair with a tr the wheel chair was to the recliner, and on the far side of th the call light handed use it appropriately			A random audit will occur by the Sa Committee of call light placement 5 for 2 weeks, then 3x/week for 4 we and then monthly x2. Audit reports reviewed by the QAPI committee w appropriate follow-up initiated.	ox/week eks, will be		
	(DON) verified R49 it should have been -At 12:22 p.m. the r "Even I was taught room, you give ther	a.m. the Director of Nursing can use her call light, and that within reach. naintenance man stated, that if you take a patient into a n the call light, or if you stop in the call light, you give it to					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 10/24/2016 APPROVED . 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT	E SURVEY IPLETED		
		245558	B. WING	i		03/2016		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	705 SIXTH STREET WINDOM, MN 56101					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 246	Continued From pa	ge 9	F 2	246				
F 248 SS=D	directed: "Purpose: To ensur method of calling fo "Procedure: 3. Whe light within easy rea of bed, stretch call I resident is able to re 483.15(f)(1) ACTIV INTERESTS/NEED The facility must pro of activities designed the comprehensive the physical, menta of each resident.	en leaving the room, place call ach of resident if in bed. If out light cord across bed so each it." ITIES MEET	F2	248	F-248	7/11/16		
	review, the facility fa activity programmin	ailed to provide consistent ig for 2 of 4 residents (R21, endent on staff to attend			Corrected Date: July 11, 2016 It is the current policy and procedure of GSS-Windom to provide an activity program to meet the needs of all residents.			
		n a recliner chair in front of the observation on 6/1/16, at			The care plans and activity assessments were reviewed and updated as necessary for R21 and R50 by July 1, 2016.			
	R21 was sleeping in the unit. Activity sta other residents in th	ion on 6/2/16, at 9:09 a.m., n a recliner in the day room on ff were providing manicures to ne activity room. At 10:56 a.m., her wheel chair in the common			Residents, who are cognitively impaired and reside outside of the unit, are at risk for similar deficient practices. Their care plans and activity assessments will be reviewed and updated as necessary by			

Facility ID: 00085

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		AND HUMAN SERVICES				FORM A	10/24/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		245558	B. WING			06/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 248	area of the facility. television but R21 v program. At 12:40 p common area of th wheel chair in front engaged in the pro- television remained sat in her wheel chain her shirt. At 1:45 p. recliner chair in the activity was schedu attend. During an observat R21 was sitting in h area of the unit. Sh 9:57 a.m., R21 was the unit, in front of a assistant (AA)-A and was asleep in her w An Activity Interest 7/10/15, indicated F gardening, singing, religious activities and document titled Bea directed staff to inv activities and offer f encourage intake. R21's care plan dat dependent on staff stimulation, and so indicated R21's pre coffee club, hymn s and listening to the R21's quarterly Min	The Price is Right was on the was not engaged in the o.m., R21 was assisted to the e unit by staff. She sat in her of the television and was not gram. At 1:03 p.m., the I on in the common area. R21 air playing with the buttons on m., R21 was sitting in a common area. An outside iled to start but R21 did not ion on 6/3/16, at 8:59 a.m., her wheel chair in the common e was asleep and snoring. At a seated in the front lobby of a bird cage with activity id three other residents. R21 wheel chair. Data Collection Tool dated R21's interests included movies, bingo, puzzles, and word games. A facility did kardex Report, undated, ite R21 to food related food, beverage of choice, and ted 9/1/15, indicated she was for activities, cognitive cial interaction. The care plan ferred activities included sing, outdoor rides, pet visits	F 2	248	July 1, 2016. The Activity Director was educated Administrator on June 23, 2016 reg the need to put all activities for all residents on the calendar. The Jul activity calendar will reflect this cha The activity staff will be re-educate the Activity Director on June 28 and 2016, and the nursing staff will be re-educated by the Activity Director Director of Nursing on June 28, 29 30, 2016, regarding inviting and as residents of all cognitive levels to v activities, the activity interests and assessments of individual resident interacting with residents with cogr deficits, and the various types of pr options for different groups of resid An audit will occur of the activity ca by the Administrator or designee for months to assure there are activitier residents with cognitive impairment An audit will occur of the activity programming by the Activity Director designee to assure residents with cognitive impairment are invited ar assisted to activities for 5x/week for weeks, then 3x/week for 4 weeks, then monthly x2. Audit reports will be reviewed by the committee with appropriate follow- initiated.	garding ly ange. d by d 29, r and , and sisting rarious s, nitive rogram dents. alendar or 4 es for t. or or nd or 4 and e QAPI	

PRINTED: 10/24/2016 FORM APPROVED

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245558	B. WING		06/03/2016	
NAME OF	PROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP CODE	00	/03/2010
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 248	 impaired and was to move from one local facility and on the unit depended of was new to the unit interests were. During an interview stated she worked stated in the afternamovies and would crafts. AA-A stated activities and would stated she had not regarding activities residents. R50 was sitting in the table alone during a 7:26 a.m. her eyes was resting on her finished eating breat the dining table. She 9:11 a.m., she was front of the television the right and her eyes R50 was still seate unit in front of the television to the right and her eyes after the right and her eyes after the right and her eyes and the right and her eyes was the table alone during the right and her eyes after the right and her eyes	otally dependent on staff to ation to another within the	F 24	48		

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	D. 0938-039 ATE SURVEY DMPLETED
		245558	B. WING			06/03/2016	
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CO		0/03/2010
GOOD S	AMARITAN SOCIETY	- WINDOM		705 : WIN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 248	asked a staff memb	per about going outside.	F 2	48			
	required staff to and staff to invite and a	ted 6/4/15, indicated she ticipate her needs and directed ssist her to bingo, bible study, and special musical					
	4/19/16, indicated F singing, discussion and family visits. A Bedside Kardex Re	Data Collection Tool, dated R50 enjoyed listening to music, , exercise, religious activities, facility document titled eport, undated, directed staff to bible study, and musical					
	severely cognitively	ted 4/22/16, indicated she was impaired and required total off to move from one location					
		on 6/3/16, at 9:10 a.m., NA-M really like to watch television go once in a while.					
	director of activities reside on the secur separate calendar f who reside on the C and R50, share a c facility even though impairment. The D/ adapted to any abil	on 6/3/16, at 9:22 a.m., the (DA) stated the residents who ed unit of the facility have a for activities, but the residents Center unit which included R21 calendar with the rest of the they have severe cognitive A stated all activities can be ity and stated they have for those residents but they are					
	not put on the caler music and small gr	or those residents but they are ndar. The AD stated R21 liked oup programming with sensory R50 was a teacher and es and small group					

Facility ID: 00085

If continuation sheet Page 13 of 32

	OF DEFICIENCIES	& MEDICAID SERVICES		TIPLE CONS	TRUCTION		<u>O. 0938-039</u> ATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				()	OMPLETED
		245558	B. WING			0	6/03/2016
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, 2	ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINDOM			HSTREET M, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC ROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 248	Continued From pa	ige 13	F 2	248			
	programs were don She stated the activ	AD stated the small group ne whenever it could be fit in vities department was fully ys per week and on those nore.					
	registered nurse (R variety of activities residents on the un checks with them."	on 6/3/16, at 9:34 a.m., N)-B stated there was a for cognitively impaired it. She stated, "I think activit She stated she was unsure o and stated she thought R2	of				
	cognitively impaired indicated small grou these residents, the activities designed residents who were attendance and res memory care unit. I occurred during the and R50, who were	ation of the facility had multi d residents, and while the AD up activities were done with ere was no evidence of for cognitively impaired e dependent on staff for activ- sided outside the secured Further, while activities had e course of the survey, R21 e dependent on staff to atten nvited to participate in the	vity				
F 282	Guidelines In Progr Unit Resident, and reviewed. The polic daily or monthly cal the current abilities further directed stat morning, afternoon	Samaritan Society, ramming For The Special Ca dated August 2012 was by directed staff to develop a endar of events according to of the residents. The policy ff to provide activities each and evening. RVICES BY QUALIFIED	5	282			7/11/16

If continuation sheet Page 14 of 32

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		245558	B. WING		06/03/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETIO
F 282	282 Continued From page 14 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.		F 28	32	
	by: Based on observat review, the facility fa deescalate behavio was to receive writt bathroom use acco addition, the facility activity programmin	NT is not met as evidenced ion, interview and document ailed to provide care to r for 1 of 1 resident (R12) who en communication for rding to the plan of care. In failed to provide onsistent ig for 3 of 4 residents (R21, e dependent on staff to attend		F-282 Corrected Date: July 11, 2016 It is the current policy and proc GSS-Windom to provide an ac program to meet the needs of residents, as well as to respect resident rights, including those dignity and preferences.	tivity all t all
	"has behavior symp with behavioral dist disorder E/B [evider [resident] refused n paranoid thoughts a occ. [occasionally] I summon staff's atte bathroom." Interver plan under "Behavior requests" included promptly. If unable her written note the assisted to the bath	ted 4/22/16, indicated R12 btoms r/t [related to] dementia urbance and depressive nced by] hx [history] of res neds or hides them d/t about being poisoned and she nollers out obscenities to ention to be escorted to the ntions identified on the care or #2- repeated bathroom "meet resident's needs to assist immediately, hand exact time that she will be proom next. Reassure her e assisted as soon as aving to wait."		 The care plans and activity ass will be reviewed and updated a necessary for R21, R46, and F 1, 2016. Residents, who are cognitively and reside outside of the unit, a for similar deficient practices. T plans and activity assessments reviewed and updated as nece July 1, 2016. The Activity Director was educa Administrator on June 23, 2010 the need to put all activities for residents on the calendar. The activity calendar will reflect this The Activity Director was educa June 3, 2016, by a Good Sama 	impaired are at risk Their care s will be ssary by ated by the 6 regarding all e July c change. ated on

Facility ID: 00085

							0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · ·	E SURVEY PLETED
		245558	B. WING			06/0	03/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET /INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 282	Continued From pa	ige 15	F 2	82			
	severe cognitive im	pairment and was totally		-	obtain needed information.		
	 dependent upon facility staff for personal cares and activities of daily living. On 5/31/16, at 4:58 p.m. R12 was observed in her wheelchair in the hallway between the nurses station and the bathroom yelling "I have to pee" while running her wheelchair into the bathroom 				The activity staff will be re-educated the Activity Director on June 28 and 2016, and the nursing staff will be		
					re-educated by the Activity Director a Director of Nursing on June 28, 29, 30, 2016, regarding inviting and ass	and isting	
	stood over R12 in fibegan to yell at R12	tood over R12 in front of the bathroom door and egan to yell at R12 while pointing at an activity assessments of individual		residents of all cognitive levels to va activities, the activity interests and assessments of individual residents	,		
	need two people to have anyone else."	use the machine and we don't R12 then attempted to get o the bathroom. R12 began to		interacting with residents with cognit deficits, and the various types of pro- options for different groups of reside		ogram	
	grab out toward LP resident "Don't you	N-B. LPN-B yelled at the hit me, my dear." R12 get past LPN-B into the			An audit will occur of the activity cale by the Administrator or designee for months to assure there are activities	4	
	bathroom stating, " go, I have to pee." I	I have to pee, that's where I LPN-B stated "I know [R12] help." LPN-B directed AA-B			residents with cognitive impairment. An audit will occur of the activity programming by the Activity Director		
	to "get help" and AA R12 then grabbed I	A-B left the memory care unit. LPN-B's arm and LPN-B			designee to assure residents with cognitive impairment are invited and	k	
	ouch, ouch" while the R12's grasp. Anoth	2's face "ouch, ouch, ouch, rying to remove her arm from er NA entered the unit, went			assisted to activities for 5x/week for weeks, then 3x/week for 4 weeks, a then monthly x2.	nd	
	to R12 she was "he bathroom." R12 let	and LPN-B and stated calmly ere to help [R12] to the go of LPN-B's arm, appeared sted to the bathroom. LPN-B			Audit reports will be reviewed by the committee with appropriate follow-up initiated.		
	was not observed to she would be assis	o write R12 a note of when ted to the bathroom.			R20 s care plan was reviewed and to be appropriate by the case mana Other residents with dementia are a	ger. it risk	
	regarding the incide LPN-B stated R12 I	wed on 5/31/16, at 5:03 p.m. ent that occurred with R12. became "very agitated, very abbing mo by the wrists and			for similar deficient practices by this nurse. LPN-B was re-educated rega dementia, therapeutic ways to intera with residents with dementia, and	arding	
		abbing me by the wrists and ed "this happens a lot with			with residents with dementia, and following care plans on June 6 and 2016, by the Director of Nursing usin		

Facility ID: 00085

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245558	B. WING		06/	06/03/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
good s	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 282	Interview with the n 6/2/16, at 12:00 p.m of behaviors and sta on a toileting plan a regarding what time bathroom. RN-C sta staff to walk away fr if R12 was being ph staff. RN-C indicate work with residents would not expect st demeaning manor. The director of nurs 6/2/16, at 1:00 p.m. training on how to o dementia and beha she expected staff the residents and act in therapeutic way even behaviors. A facility policy titled Resident Dignity, da reviewed. The polic maintaining the dign assist with respecting rights. R21's care plan dat dependent on staff stimulation, and so indicated R21's pre coffee club, hymn s and listening to the Minimum Data Set	urse manager RN-C on n. revealed R12 had a history aff was directed to keep R12 and hand notes to her a she would be assisted to the ated that she would expect rom R12 and reapproach later hysically aggressive towards ed staff have been trained to who have behaviors and aff to treat R12 in a sing (DON) was interviewed on and stated all staff receive are for residents with viors. The DON further stated to follow the care plan for all	F 28	 written and on-line materials. All nursing staff will be re-educ Director of Nursing on June 28 30, 2016 regarding following the and therapeutic interventions in with dementia. An observation audit will be control the Director of Nursing or designation of the therapeutic interventions listed plan of residents with dementi for 2 weeks, then 3x/week for and then monthly x2. Audit re- reviewed by the QAPI commit appropriate follow-up initiated. 	3, 29, and he care plan for persons onducted by gnee to g the d on the care a, 5x/week 4 weeks, ports will be tee with		

If continuation sheet Page 17 of 32

	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		TE SURVEY
FOUNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G		
	245558				/03/2016
PROVIDER OR SUPPLIER				E	
AMARITAN SOCIETY	- WINDOM				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETIO DATE
Continued From pa	ige 17	F 28	2		
one location to ano the unit.	ther within the facility and on				
television during an 10:43 a.m. During a 9:09 a.m., R21 was day room on the un manicures to other At 10:56 a.m., R21 in the common area Right was on the tele engaged in the pro- assisted to the com She sat in her where and was not engag p.m., the television area. R21 sat in he buttons on her shirt in a recliner chair in activity was schedu attend. During an o a.m., R21 was sittir common area of th snoring. At 9:57 a.m.	a observation on 6/1/16, at an observation on 6/2/16, at a sleeping in a recliner in the bit. Activity staff were providing residents in the activity room. was sitting in her wheel chair a of the facility. The Price is elevision but R21 was not gram. At 12:40 p.m., R21 was mon area of the unit by staff. el chair in front of the television ed in the program. At 1:03 remained on in the common r wheel chair playing with the t. At 1:45 p.m., R21 was sitting in the common area. An outside iled to start but R21 did not bservation on 6/3/16, at 8:59 ng in her wheel chair in the e unit. She was asleep and n., R21 was seated in the front				
residents. R21 was R46's quarterly MD was severely cogni dependent on staff	S dated 4/1/16, indicated she tively impaired and totally for all activities of daily living.				
	PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa one location to ano the unit. R21 was sleeping i television during ar 10:43 a.m. During a 9:09 a.m., R21 was day room on the ur manicures to other At 10:56 a.m., R21 in the common area Right was on the television area. R21 sat in her when and was not engag p.m., the television area. R21 sat in her buttons on her shirt in a recliner chair ir activity was schedu attend. During an o a.m., R21 was sittir common area of th snoring. At 9:57 a.r lobby of the unit, in activity assistant (A residents. R21 was R46's quarterly MD was severely cogni dependent on staff	IDENTIFICATION NUMBER: 245558 PROVIDER OR SUPPLIER AMARITAN SOCIETY - WINDOM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 one location to another within the facility and on the unit. R21 was sleeping in a recliner chair in front of the television during an observation on 6/1/16, at 9:09 a.m., R21 was sleeping in a recliner in the day room on the unit. Activity staff were providing manicures to other residents in the activity room. At 10:56 a.m., R21 was sitting in her wheel chair in the common area of the facility. The Price is Right was on the television but R21 was not engaged in the program. At 12:40 p.m., R21 was assisted to the common area of the unit by staff. She sat in her wheel chair in front of the television and was not engaged in the program. At 1:03 p.m., the television remained on in the common area. R21 sat in her wheel chair playing with the buttons on her shirt. At 1:45 p.m., R21 was sitting in a recliner chair in the common area. An outside activity was scheduled to start but R21 did not attend. During an observation on 6/3/16, at 8:59 a.m., R21 was sitting in her wheel chair in the common area of the unit. She was asleep and snoring. At 9:57 a.m., R21 was seated in the front lobby of the unit, in front of a bird cage with activity assistant (AA)-A and three other residents. R21 was asleep in her wheel chair.	IDENTIFICATION NUMBER: A. BUILDIN 245558 B. WING PROVIDER OR SUPPLIER AMARITAN SOCIETY - WINDOM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 17 one location to another within the facility and on the unit. F 28. R21 was sleeping in a recliner chair in front of the television during an observation on 6/1/16, at 9:09 a.m., R21 was sleeping in a recliner in the day room on the unit. Activity staff were providing manicures to other residents in the activity room. At 10:56 a.m., R21 was sitting in her wheel chair in the common area of the facility. The Price is Right was on the television but R21 was not engaged in the program. At 12:40 p.m., R21 was assisted to the common area of the unit by staff. She sat in her wheel chair in front of the television and was not engaged in the program. At 1:03 p.m., the television remained on in the common area. R21 sat in her wheel chair playing with the buttons on her shirt. At 1:45 p.m., R21 was satiting in a recliner chair in the common area. An outside activity was scheduled to start but R21 did not attend. During an observation on 6/3/16, at 8:59 a.m., R21 was sitting in her wheel chair in the common area of the unit. She was asleep and snoring. At 9:57 a.m., R21 was seated in the front lobby of the unit, in front of a bird cage with activity assistant (AA)-A and three other residents. R21 was asleep in her wheel chair. R46's quarterly MDS dated 4/1/16, indicated she was severely cognitively impaired and totally	IPE CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245558 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETIX TAG Continued From page 17 one location to another within the facility and on the unit. IP R21 was sleeping in a recliner chair in front of the television during an observation on 6/1/16, at 10:43 a.m. During an observation on 6/2/16, at 9:09 a.m., R21 was sleeping in a recliner in the day room on the unit. Activity staff were providing manicures to other residents in the activity room. At 10:56 a.m., R21 was sitting in her wheel chair in the common area of the tacility. The Price is Right was on the television but R21 was not engaged in the program. At 12:40 p.m., R21 was assisted to the common area of the tunit by staff. She sat in her wheel chair in front of the television and was not engaged in the program. At 1:03 p.m., the television remained on in the common area. R21 sat in her wheel chair in front of 3/16, at 8:59 a.m., R21 was sitting in her wheel chair in the common area of the unit. She was asleep and snoring. At 9:57 a.m., R21 was sateled in the front lobby of the unit, in front of a bird cage with activity assistant (AA)-A and three other residents. R21 was asleep in her wheel chair. R46's quarterly MDS dated 4/1/16, indicated she was severely cognitively impaired and totally dependent on staff for all activities of daily living.	IF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COT 245558 B. WING 06 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET AMARITAN SOCIETY - WINDOM STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101 ID PROVIDERS PLAN OF CORRECTIVE ACTION NHOULD BE CROCH CORRECTIVE ACTION NHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX PROVIDERS PLAN OF CORRECTIVE ACTION NHOULD BE Continued From page 17 one location to another within the facility and on the unit. F 282 Consistence activity and on the unit. R21 was sleeping in a recliner chair in front of the television during an observation on 6/1/16, at 10:43 a.m. During an observation on 6/1/16, at 10:43 a.m., R21 was sleeping in a recliner in the dativity torom. At 10:56 a.m., R21 was sleeping in a recliner their in the common area of the unit by staff. She sat in her wheel chair in front of the television and was not the gloxing with the buttors on her shirt. At 1:45 p.m., R21 was saleep and anotiside activity assistent (AA)-A and three other residents. R21 was asleep in her wheel chair in the common area. An outside activity assistent (AA)-A and three other residents. R21 was asleep and snoring. At 9:57 a.m., R21 was seated in the front lobby of the unit, in front of a bird cage with activity saff were availed and totally dependent on staff for all activities of daily living. Staff add advirtue of all activities of daily living.

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558			TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		B. WING			06/03/2016	
NAME OF	PROVIDER OR SUPPLIER	240000	D. 11110 _	STREET ADDRESS, CITY, STATE, ZIP CODE	06/	03/2016
GOOD SAMARITAN SOCIETY - WINDOM				705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 282	of the unit. She was television during an a.m. During an obs a.m., R46 was in a common area of the front of the televisio dining room, the fac hymns and reciting meal. R46 was not in the small dining r on. At 12:09 p.m., F in her reclining whe her in bed. R46 did at 2:00 p.m. During 9:57 a.m., R46 was front entrance of the bird aviary. She was R50's care plan dat required staff to an staff to invite and as devotions, pet visits programs. An annu indicated she was s and required total a from one location to R50 was sitting in h table alone during a 7:26 a.m. her eyes was resting on her finished eating brea the dining table. Sh 9:11 a.m., she was front of the televisio the right and her ey R50 was still seated unit in front of the te	s sleeping in front of the observation on 6/1/16, at 9:24 ervation on 6/2/16, at 9:19 reclining wheel chair in the e unit. She was sleeping in on. At 11:36 a.m. in the main cility chaplain was singing a prayer before the noon in attendance, she was sitting room on the unit she resides R46 was sleeping in her room eel chair, at 1:47 p.m., staff put not attend the outside activity an observation on 6/3/16, at s sitting in her wheelchair in the e facility sitting in front of the s asleep. ted 6/4/15, indicated she ticipate her needs and directed ssist her to bingo, bible study, s and special musical al MDS dated 4/22/16, severely cognitively impaired assistance from staff to move	F 28	82		

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STATEMEN	F OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
AND PLAN (ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245558	B. WING _			/03/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 705 SIXTH STREET	E		
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE	
F 282	At 11:29 a.m., R50 dining room by staf staff member abou afternoon after the activity. At 1:49 p.m attend the outside a During an interview nursing assistant (N the unit depended of was new to the unit interests were. NA like to watch televis once in a while. During an interview stated she worked stated in the mornin residents to sit in fr stated they often sl afternoon the resid would go to the act stated R21 did not would just observe. the activity room fo participate, she just During an interview director of activities resided on the Cen R46 and R50 share facility even though impairment. The D separate activities f not put on the caler group programs are in. She stated the a staffed only four da	was escorted to the main f. R50 was heard asking a t going outside in the chaplain announced the n., R50 was in bed. She did not activity. on 6/3/16, at 9:08 a.m., NA)-M stated the activities on on the person. She stated R21 t and she was unsure what her -M stated R50 did not really sion but would go to bingo on 6/3/16, at 9:58 a.m., AA-A both evenings and days. She ng she would bring the ont of the nird aviary but ept. She stated in the ents watched movies and ivity room for crafts. AA-A participate in the activities and . She stated R46 also went to r crafts but was not able to	F 2	82			

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	TOF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION		. 0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		G	· · /	COMPLETED	
		245558	B. WING		06/	/03/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 282 F 373 SS=D	resident was asses and if there was a s when cognition or a stated she was una activities each resic could view whether self-directed activity A policy titled Good Plan, and dated Jun policy directed staff care plan that empl development of the the resident receive services. 483.35(h) FEEDING TRAINING/SUPER A facility may use a defined in §488.301 assistant has succe State-approved trai requirements of §44 residents; and the u consistent with Staff A feeding assistant supervision of a reg practical nurse (LPI In an emergency, a supervisory nurse f system. A facility must ensu	sed upon admission, annually significant change, as well as ability changes. However, she ability completed, a comprehensive hasizes the care and CASST - VISION/RESIDENT paid feeding assistant, as a of this chapter, if the feeding assfully completed a ning course that meets the 83.160 before feeding use of feeding assistants is a law. must work under the gistered nurse (RN) or licensed	F 28			7/11/16	

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TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS		(X3) DA	0. 0938-039 TE SURVEY MPLETED
		A. BUILDING			001	00	
		245558	B. WING			06	/03/2016
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	' - WINDOM			M, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI ROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 373	Complicated feedir not limited to, diffic aspirations, and tul The facility must bac charge nurse's ass latest assessment NOTE: One of the regulatory requirent feeding assistants program with the for specified at §483.1 o A State-approver feeding assistants hours of training in Feeding technic Assistance with Communication Appropriate resp Safety and eme the Heimlich mane Infection control Resident rights. Recognizing chai inconsistent with the importance of repo supervisory nurse. A facility must main used by the facility have successfully of for paid feeding assist This REQUIREME	ng problems include, but are ulty swallowing, recurrent lung be or parenteral/IV feedings. ase resident selection on the sessment and the resident's and plan of care. specific features of the nent for this tag is that paid must complete a training ollowing minimum content as 60: d training course for paid must include, at a minimum, 8 the following: ques. feeding and hydration. and interpersonal skills. ponses to resident behavior. regency procedures, including uver. I. anges in residents that are heir normal behavior and the orting those changes to the tain a record of all individuals as feeding assistants, who completed the training course	F	73			
	used by the facility have successfully of for paid feeding as This REQUIREME by:	as feeding assistants, who completed the training course sistants.		F-37	73		

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES				APPROVE 0938-039	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	· · /	(X3) DATE SURVEY COMPLETED	
		245558	B. WING _		06/	03/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET			
GOOD SAMARITAN SOCIETY - WINDOM							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 373	review, the facility fr (R110) reviewed for assessed to be safe Findings include: During an entrance administrator on 5/2 administrator indica paid feeding assista certified nursing as: R110 admitted to the diagnosis of demer care unit. R110's ac (MDS) assessment R110's cognition wa required staff assiss plan dated 5/17/16, required staff assiss feeding assistants we eating. R110's unda R110 required assiss identified no paid fe assist R110. On 5/31/16, at 5:34 (AA)-B was observed meal. AA-B was ob residents seated at unit. -At 5:47 p.m. AA-B between R89 and F place pureed meat mouth and said " F R110 kept mouth cl	ailed to ensure 1 of 1 residents r assistance with eating, was ely fed by a non-nursing staff. conference with the 21/16, at 12:05 p.m. the ated the facility did not utilize ants and all activity staff were	F 37	 Corrected Date: July 11, 2016 It is the current policy and proceed GSS-Windom to follow all feeding assistant guidelines. R110 care plan was reviewed and to be appropriate. Residents at risk of this deficient are those who have complicated problems. AA-B was re-educated regarding the feeding assistant p who they are able to assist and w cannot on June 24, 2016 by the of Nursing. All nurses will be re-educated by Director of Nursing on June 28, 30, 2016, regarding the feeding assistant will feed. An observation audit will occur of feeding assistant and who he is by the Director of Nursing or dese each time the assistant is performed uty x4 weeks. The facility employ other feeding assistants. Audit r be reviewed by the QAPI commit appropriate follow-up initiated. 	g d found practice feeding d policy and vho they Director the 29, and assistant direct who f the feeding ignee ming this pys no eports will		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		245558	B. WING		06	/03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 373	attempted to push t AA-B continued to h saying "open your n mouth please. " W mouth, AA-B set the R110 if she would li provided the cup of from it. -At 5:55 p.m. AA-B potatoes in her milk AA-B then gave R1 drank the milk. -At 5:56 p.m. AA-B of mashed potatoes with a knife and har -At 5:57 p.m. R110 drink of milk. AA-B mixed with mashed meal. -At 6:02 p.m. AA-B mashed potatoes to offer her drinks of n resident walked aw -R110 was not offer during the evening bite of pureed meat mixed with mashed meal. -AA-B was interview and stated R110's o potatoes are put in On 6/3/16 at 12:40 employee files AA-E feeding assistant ar assistant training. T	the AA-B's hand away and hold the spoon to R110'S teeth nouth please, open your hen R110 did not open her e spoon down and asked ike a drink of milk. AA-B milk to R110 and she drank put a spoon full of R110 ' S and stirred them with a knife. 10 the milk to drink. R110 added an additional spoonful s to the milk, stirred the milk nded the milk to R110 to drink. was provided an additional continued to offer the milk I potatoes during the evening added another spoonful of o R110's milk and continued to nilk until 6:07 p.m. when the	F 3	73		

If continuation sheet Page 24 of 32

STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039[.]</u> E SURVEY IPLETED
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	IG	CON	IFLETED
		245558	B. WING _		06/	03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET		
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 373 F 431 SS=D	On 6/3/16, at 12:52 (DON) confirmed A assistant and shoul R110. The DON co on a list of residents were not to assist w indicated AA-B and the meal, should be assistants are and assist. A paid feeding assis by the facility. 483.60(b), (d), (e) E LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs in accurate reconciliat reconciled. Drugs and biologica labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartmer	p.m. the director of nursing A-B was a paid feeding d not have been assisting nfirmed R110 was identified s that paid feeding assistants <i>i</i> th meals. The DON further the nurse who is supervising aware of who paid feeding which residents they can stant policy was not provided DRUG RECORDS, UGS & BIOLOGICALS hploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be ice with currently accepted les, and include the ory and cautionary e expiration date when State and Federal laws, the II drugs and biologicals in its under proper temperature t only authorized personnel to	F 37			7/11/16

If continuation sheet Page 25 of 32

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
	of Connection	IDENTIFICATION NUMBER.	A. BUILD	ING .		COM	LETED
		245558	B. WING			06/0	03/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		7	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 431	Continued From page 25 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:			131			
	Based on observat review, the facility fa were securely store reviewed. In additio of 3 medication car appropriately secure Findings include: On 5/31/16 betweet an observation was unit of medications medication cart. A cup with crushed m sitting on the medic bottles of liquid Gat (milligrams/milliliter) labels.	n 4:58 p.m. through 5:04 p.m. made on the memory care being stored on the clear, non-labeled, medication edications in it was observed ation cart as well as two large papentin 250 mg/ml) with R20's name on the hurse (LPN)-B was interviewed			 F-431 Corrected Date: July 11, 2016 It is the current policy and procedur GSS-Windom to dispense and store drugs according to current medicati administration guidelines. The medication for R20 was correct the time of the survey observation. nurse in charge of the 200-wing car corrected her mistake at the time of survey observation, when she was corrected by the surveyor. As all residents are at risk of this de practice, all nurses and trained medicates will be re-educated by the Dir of Nursing on proper medication administration procedures on June and RNC for the R and R a	e on ted at The t f the eficient dication ector 28, 29,	
	clear medication cu there were crushed including Levothyro	confirmed she had left the p on top of the cart and stated medications in the cup xine (thyroid medication) and the heart). In addition, LPN-B			and 30, 2016. LPN-B and RN-C red individualized education on June 6, and June 2, 2016, respectively, by t Director of Nursing.	2016	

Facility ID: 00085

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	OF DEFICIENCIES				DUCTION		<u>. 0938-039</u> E SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONST			E SURVEY IPLETED	
		245558	B. WING _			06/	03/2016	
NAME OF	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP C	ODE		
good s	AMARITAN SOCIETY	- WINDOM		705 SIXTH	I STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COF EACH CORRECTIVE ACTION OSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 431	on top of the cart. At 5:11 p.m. on 5/3 Gabapentin continu- side of the medicat was "going on brea cart, LPN-B was ob bottles of Gabapen of the cart and walk During continuous of cart from 4:58 p.m. two bottles of Gaba medication cart. At and confirmed she cart. The director of nurs 6/2/16, at 11:50 a.m Gabapentin should the medication cart expect staff to pour prescribed, and to p refrigerator which w On 6/1/16, at 9:34 a (a nurse from the 2 unlock a medication top while looking fo then shut the medic in, and proceeded a the hallway to give lock the cart, nor pi walking away from unlocked medicatio time, the surveyor a away from the cart keys on top. RN-C	abapentin bottles had been left 1/16, the two bottles of ued to be observed on the left ion cart. LPN-B stated she k" and locked the medication oserved to move the two tin to the right side of the top ked away. observation of the medication until 6:10 p.m. on 5/31/16, the apentin remained on top of the 6:10 p.m., LPN-B returned had left the Gabapentin on the sing (DON) was interviewed on n. The DON verified R20's not have been left on top of the top of the dosage of medication put the bottle back in the	F 4:	An ob admir of Nu weeks month by the	eservation audit will occ histration and storage b rsing or designee, 3x/v s, then weekly x 4 wee hly x2. Audit reports w e QAPI committee with -up initiated.	by the Director veek for 2 ks, and then ill be reviewed		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245558	B. WING		06/03/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/03/2010
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTIO
F 431 F 463 SS=D	pens, and numerou residents. During interview with DON verified she'd left the medication top. The DON verifi- be kept locked and the person response. The facility policy eff Dispensing and Sto 12/15, indicated: "m locked medication of the person passing director of nursing shave access to the storage areas." 483.70(f) RESIDEN ROOMS/TOILET/B The nurses' station resident calls through from resident room facilities. This REQUIREMEN by: Based on observation	vas noted to contain insulin is oral medications for th the DON at 3:30 p.m., the been made aware RN-C had cart unlocked with the keys on ied the medication cart should the keys should be kept with bible for passing medications. Intitled Acquisition, Receiving, orage of Medications dated nedication will be stored in a cart, drawer or cupboard. Only the medications and the services will be permitted to keys to the medications IT CALL SYSTEM - ATH must be equipped to receive gh a communication system s; and toilet and bathing NT is not met as evidenced tion, interview, and document ailed to assure a room call g for 1 of 35 residents (R107)	F 43		ng call

Facility ID: 00085

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · /	E SURVEY PLETED	
		245558	B. WING _			06/0	03/2016	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIOI DATE	
F 463	5/25/16, identified F impairment, however for Stage I data. The required two persors one person assist f living except eating indicated R107 required bladder/bowel incon falls. The care plan remind the resident dropped items and grabber or ask for a On 5/31/16, at 4:24 room was observed her bed. R107 was bed, was able to ide which resulted in it assistant (NA)-A an verified the call ligh stating "I will contact During an interview environmental assis notified that the call at which time he rep check every room of housekeeping super responsible for that During an interview stated she conducts functioning. The cal maintenance and the	imum Data Set (MDS) dated R107 had severe cognitive er was able to be interviewed e MDS indicated R107 in assist for bed mobility and or all other activities of daily . The care plan dated 5/20/16, uired staff assist to manage ntinence and was at risk for indicated staff needed to anot to bend over to pick up encourage the use of a assistance. p.m. the call light in R107's d to be pinned to the sheets on sitting up on the edge of the entify and press the call light, being nonfunctional. Nursing id registered nurse (RN)-A t was not functional, with RN-A et maintenance." on 6/3/16, at 11:37 a.m. stant (EA) stated he was l light did not work on 5/31/16 placed it. EA stated he used to quarterly, but the ervisor (HS) has been since January. on 6/3/16, at 12:03 p.m. HS is quarterly audits on call light esident and typically a NA or tell maintenance if it wasn't	F 4	63	The call light for 107 was fixed at the of the survey observation. All resident call lights were checked maintenance staff by June 24, 2010 assure operability and were repaired needed. The facility has a successful system identifying and fixing equipment via Maintenance Hotline, as well as quichecks of each room, including the lights. EA was re-educated about the procedures on June 22, 2016. All maintenance staff will be re-educated June 29, 2016. Audits of all call lights will be done bi-weekly for 6 weeks, then monthly the Safety Committee. Audit result be reviewed by the QAPI Committee further recommendations.	d by 6, to ed if n for our arterly call nese red on y x3 by s will		

If continuation sheet Page 29 of 32

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		. 0938-039 E SURVEY IPLETED
	CONTECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG	COM	
		245558	B. WING		06/	03/2016
	PROVIDER OR SUPPLIER	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIOI DATE
F 463	Continued From pa	ge 29	F 40	53		
F 465 SS=D	stated "if staff or an stated that staff wo Hotline system which then address it, exc emergency, "we do nonfunctioning call did not have a writte Review of the facilite dated September 2 was to ensure reside calling for assistant to report nonfunction 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pre- sanitary, and comfor residents, staff and This REQUIREMENT by: Based on observant review, the facility free quipment in a clear promote sanitation kitchen. This practice	lights." EA verified the facility en policy. y Procedure for Call Light 012, indicated the purpose lents always had a method of ce but lacked direction on how uning call lights. AL/SANITARY/COMFORTABL povide a safe, functional, ortable environment for	F 4	F-465 Corrected Date: July 11, 2016 It is the current policy and proced GSS-Windom to provide a clean sanitary kitchen environment. The griddle and oven were clean June 2, 2016.	and	7/11/16
		our on 5/31/16, at 12:20 p.m. tion concerns were observed		All other kitchen equipment is at this deficient practice and will be		

Facility ID: 00085

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ATEMENT		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDI	NG _		COM	
		245558	B. WING			06/	03/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		-	05 SIXTH STREET /INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 465	Continued From pa	age 30	F4	65			
		he Director of Dietary (DD):			and followed up on as appropriate 1, 2016 for cleanliness.	by July	
	- On the six burner stove, all six knobs and long handle on the oven were sticky with a buildup of a brown/black substance on and around the knobs. DD stated the stove was cleaned after each meal.				All dietary staff will be re-educated cleaning practices by July 11, 2016		
	sticky with a buildu	s on the flat top griddle were dirty and n a buildup of a brown/black substance. follow-up kitchen tour on 6/2/16, at 1:25			An audit by the Dietary Director or designee will occur of kitchen equi cleanliness, 5x/week for 2 weeks, 3x/week for 2 weeks, and then we	then ekly x4	
		anitation concerns were			weeks. Audit reports will be review the QAPI committee with appropria follow-up initiated.		
	grates had a buildu debris in the corner each set of grates. situated below the splatter down the fir and food debris cal of the handle. All si	by with three sets of two ip of a greasy black food rs of the grates and between The outside of the oven door stove burner stove had food ront of it and there was grease ked on and around the corners ix knobs had a heavy buildup stance on and around the					
	a sticky, brown gre down the front pan units needed clean cleaning schedule,	e front plate was covered with asy residue with food spills el of the unit. DD verified both ing and although they have a she was not sure if the two ed for deep cleaning.					
	stated the deep cle the cleaning duty list	on 6/3/16, at 10:55 a.m. DD paning of the stove was not on st "but it is now." DD verified duties was the policy and in ev.					

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		AND HUMAN SERVICES				FORM	10/24/2016 APPROVED 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245558	B. WING	i		06/	03/2016
NAME OF F	PROVIDER OR SUPPLIER	·			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	griddle or the six bu Review of the unda policy indicated the cleaning the "grill" a	le cleaning of either the flat top	F 4	465			

Facility ID: 00085

PRINTED: 06/28/2016 5558025 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A: BUILDING 01 - MAIN BUILDING 01 245558 B. WING 06/01/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **705 SIXTH STREET GOOD SAMARITAN SOCIETY - WINDOM** WINDOM, MN 56101 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** 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 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 01, 2016. At the time of this survey, Good Samaritan Society Windom was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:

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

TITLE

(X6) DATE 06/27/2016

Electronically Signed

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

STATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	0938-039
AND PLAN C	OF CORRECTION		A. BUILDING	G 01 - MAIN BUILDING 01	CON	IPLETED
		245558	B. WING		06/	01/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
K 000	Angela Kappenma	state.mn.us nitney@state.mn.us> and	K 000)		
	DEFICIENCY MUS FOLLOWING INF					
	1. A description of to correct the defice	what has been, or will be, done siency.				
	2. The actual, or p	roposed, completion date.				
	responsible for co	or title of the person rrection and monitoring to rence of the deficiency.				
	building with partia constructed at five building was const additions in 1962, buildings were det	Society Windom is a one-story al basement, and was a different times. The original tructed in 1959, with building 1972, 1994 and 2000. All ermined to be of Type II(111) facility is fully sprinklered.				
	detection in the co open to the corrido automatic fire dep	a fire alarm system with smoke rridors, including all spaces ors, which are monitored for artment notification. The facility 78 beds and had a census of 77 ey.				
14 005	NOT MET as evid		K 001	-		6/29/16
K 025 SS=D	Smoke barriers sh	AFETY CODE STANDARD all be constructed to provide at our fire resistance rating and	K 02	0		0123/10

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/28/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
	2	245558	B. WING		06/0	01/2016
	PROVIDER OR SUPPLIER	- WINDOM	đ	STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 025	constructed in acco barriers shall be pe atrium wall. Window fire-rated glazing or steel frames. 8.3, 19.3.7.3, 19.3.7 This STANDARD is Smoke barriers shale east a one half hou constructed in acco barriers shall be pe atrium wall. Window fire-rated glazing or steel frames. 8.3, 19.3.7.3, 19.3.7 FINDINGS INCLUE During Facility Insp between the hours observation reveale electrical cables ab 100 wing smoke ba barrier.	Ardance with 8.3. Smoke rmitted to terminate at an ws shall be protected by by wired glass panels and 7.5 s not met as evidenced by: all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke rmitted to terminate at an ws shall be protected by by wired glass panels and 7.5 DE: ection on June 01, 2016, of 12:30 PM and 3:00 PM, ed penetrations around ove the lay in ceilings at the arrier and the 500 wing smoke	KO	 Preparation and execution of this response and plan of correction do constitute an admission or agreem the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan correction is prepared and/or exect solely because it is required by the provisions of Federal and State law the purposes of any allegation that facility is not in substantial complia with Federal requirements of partice this response and plan of correction constitutes the facility's allegation of compliance in accordance with sec 7305 of the State Operations Manu K-25 Corrected Date: June 29, 2016 The penetrations in the walls were repaired on June 9, 2016. All othe were checked and found to be con or were corrected as necessary on 9, 2016. Education regarding staff monitorir following up with outside contracto assure any penetrations were fixed time of service will be provided to maintenance staff on June 29, 201 	ent by she of uted v. For the nce sipation, n of stion ual. r walls pliant June ng and rs to d at the	

.

Facility ID: 00085

If continuation sheet Page 3 of 4

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245558 B. WING 06/01/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **705 SIXTH STREET GOOD SAMARITAN SOCIETY - WINDOM** WINDOM, MN 56101 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 025 Continued From page 3 K 025 The Safety Coordinator and Maintenance Director will monitor the facility for future issues through the Safety Meeting audits and the QAPI committee. K 144 NFPA 101 LIFE SAFETY CODE STANDARD 6/29/16 K 144 SS=D Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised K-144 under load for 30 minutes per month and shall be Corrected Date: June 29, 2016 in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA Re-education was provided to the nursing home maintenance supervisor regarding 110) the policy and importance of emergency generator weekly checks on June 22, 2016. All maintenance staff will be FINDINGS INCLUDE: re-educated on the weekly generator **During Facility Inspection and Documentation** checks on June 29, 2016. Review on June 01, 2016, between the hours of The Safety Coordinator and Maintenance 12:30 PM and Director will monitor the facility for future 3:00PM, the following was discovered: issues through the Safety Meeting audits and the QAPI committee. 1.) Documentation review revealed that the weekly generation inspection was not documented during the period from April 25, 2016 to May 6, 2016. This deficient practice was verfied by the Maintenance Supervisor.

PRINTED: 06/28/2016



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted June 17, 2016

Ms. Nancy Wepplo, Administrator Good Samaritan Society - Windom 705 Sixth Street Windom, Minnesota 56101

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5558024 & H5558011

Dear Ms. Wepplo:

The above facility was surveyed on May 31, 2016 through June 3, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5558011 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. Good Samaritan Society - Windom June 17, 2016 Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gloria Derfus, Unit Supervisor at (651) 201-3792.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00085	B. WING		06/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET , MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 06/27/16

Electronically Signed

STATE FORM

6899

If continuation sheet 1 of 41

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING		06/	03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	VE ACTION SHOULD BE CO ED TO THE APPROPRIATE		
2 000	Continued From pa	age 1	2 000				
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading the date your orders will be lectronically submitting to the ment of Health.					
	this Department's s and the following co Please indicate in y correction that you	to June 3, 2016 surveyors of staff, visited the above provider orrection orders are issued. your electronic plan of have reviewed these orders, he when they will be completed					
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for					
	column entitled "IC statute/rule out of o "Summary Stateme and replaces the "T correction order. TI findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.					
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, NN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.					

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00085	B. WING		06/03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
		complaint number H5558011 he time of the extended survey e unsubstantiated.	,		
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		7/11/16
		omprehensive plan of care personnel involved in the 			
	by: Based on observati review, the facility f deescalate behavio was to receive writt bathroom use acco addition, the facility activity programmin	ent is not met as evidenced on, interview and document ailed to provide care to or for 1 of 1 resident (R12) who en communication for rding to the plan of care. In failed to provide onsistent og for 3 of 4 residents (R21, re dependent on staff to attend		Acknowledged	
	Findings include:				
	"has behavior symp with behavioral dist disorder E/B [evide [resident] refused n	ted 4/22/16, indicated R12 otoms r/t [related to] dementia urbance and depressive nced by] hx [history] of res neds or hides them d/t about being poisoned and she			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING		06/	06/03/2016	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE. ZIP CODE			
		705 SIXT	H STREET				
GOODS	AMARITAN SOCIETY	- WINDOM WINDON	I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	ge 3	2 565				
	summon staff's atte bathroom." Interver plan under "Behavin requests" included promptly. If unable her written note the assisted to the bath often that she will b possible if she is ha Review of R12's Sig Assessment dated severe cognitive im	gnificant Change MDS 4/29/16, indicated R12 had pairment and was totally cility staff for personal cares					
	her wheelchair in th station and the bath while running her w door. Licensed prace stood over R12 in fi began to yell at R12 assistant (AA)-B "H need two people to have anyone else." past LPN-B and inte grab out toward LP resident "Don't you continued to try to g bathroom stating, " go, I have to pee." I but I don't have any to "get help" and AA R12 then grabbed I began to yell in R12	p.m. R12 was observed in he hallway between the nurses proom yelling "I have to pee" theelchair into the bathroom ctical nurse (LPN)-B then ront of the bathroom door and 2 while pointing at an activity le can't use the machine, we use the machine and we don' R12 then attempted to get to the bathroom. R12 began to N-B. LPN-B yelled at the hit me, my dear." R12 get past LPN-B into the I have to pee, that's where I LPN-B stated "I know [R12] whelp." LPN-B directed AA-B A-B left the memory care unit. _PN-B's arm and LPN-B 2's face "ouch, ouch, ouch, rying to remove her arm from					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
		00085	B. WING		06/	06/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET //, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	age 4	2 565				
	bathroom." R12 let calm and was assis was not observed t she would be assis LPN-B was intervie regarding the incide LPN-B stated R12 quickly and was gra	ere to help [R12] to the go of LPN-B's arm, appeared sted to the bathroom. LPN-B o write R12 a note of when ited to the bathroom. wed on 5/31/16, at 5:03 p.m. ent that occurred with R12. became "very agitated, very abbing me by the wrists and ted "this happens a lot with					
	6/2/16, at 12:00 p.r of behaviors and st on a toileting plan a regarding what time bathroom. RN-C st staff to walk away f if R12 was being pl staff. RN-C indicat work with residents	nurse manager RN-C on n. revealed R12 had a history taff was directed to keep R12 and hand notes to her e she would be assisted to the ated that she would expect from R12 and reapproach later hysically aggressive towards red staff have been trained to a who have behaviors and taff to treat R12 in a					
	6/2/16, at 1:00 p.m training on how to o dementia and beha she expected staff residents and act ir	sing (DON) was interviewed or . and stated all staff receive care for residents with aviors. The DON further stated to follow the care plan for all n a professional and en with residents who exhibit					
	Resident Dignity, d reviewed. The polic maintaining the dig	d Good Samaritan Society ated February 2013, was cy indicated a purpose of nity of all residents and to ng and abiding by resident					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00085	B. WING		06/	03/2016
AME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
iood s	AMARITAN SOCIETY	- WINDOM	H STREET I, MN 56101			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
2 565	Continued From pa	ge 5	2 565			
	rights.					
	stimulation, and soci indicated R21's pre- coffee club, hymn s and listening to the Minimum Data Set indicated she was s and was totally dep	for activities, cognitive cial interaction. The care plan ferred activities included ing, outdoor rides, pet visits radio. R21's quarterly (MDS) dated 3/25/16, severely cognitively impaired endent on staff to move from ther within the facility and on				
	television during an 10:43 a.m. During a 9:09 a.m., R21 was day room on the un manicures to other At 10:56 a.m., R21 in the common area Right was on the te engaged in the prog assisted to the com She sat in her whee and was not engag p.m., the television area. R21 sat in her buttons on her shirt in a recliner chair in activity was schedu attend. During an o a.m., R21 was sittir common area of the snoring. At 9:57 a.m. lobby of the unit, in	n a recliner chair in front of the observation on 6/1/16, at an observation on 6/2/16, at sleeping in a recliner in the it. Activity staff were providing residents in the activity room. was sitting in her wheel chair a of the facility. The Price is levision but R21 was not gram. At 12:40 p.m., R21 was mon area of the unit by staff. el chair in front of the televisior ed in the program. At 1:03 remained on in the common r wheel chair playing with the the common area. An outside led to start but R21 was sitting the common area. An outside led to start but R21 did not bservation on 6/3/16, at 8:59 ng in her wheel chair in the e unit. She was asleep and n., R21 was seated in the front front of a bird cage with A)-A and three other				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING		06/	06/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	age 6	2 565				
	was severely cogni dependent on staff Her care plan dated thought processes her needs and dire her to bingo, outdo and bible study. R46 was in a reclin of the unit. She was television during ar a.m. During an obs a.m., R46 was in a common area of th front of the television dining room, the fa- hymns and reciting meal. R46 was not in the small dining on. At 12:09 p.m., H in her reclining whe her in bed. R46 did at 2:00 p.m. During 9:57 a.m., R46 was front entrance of th bird aviary. She was	DS dated 4/1/16, indicated she itively impaired and totally for all activities of daily living. d 5/14/16, indicated impaired and inability to communicate cted staff to invite and assist or time, happy hour, worship, hing chair in the common area s sleeping in front of the n observation on 6/1/16, at 9:24 servation on 6/2/16, at 9:19 reclining wheel chair in the ne unit. She was sleeping in on. At 11:36 a.m. in the main cility chaplain was singing a prayer before the noon in attendance, she was sitting room on the unit she resides R46 was sleeping in her room eel chair, at 1:47 p.m., staff put I not attend the outside activity g an observation on 6/3/16, at s sitting in her wheelchair in the is asleep. ted 6/4/15, indicated she					
	required staff to an staff to invite and a devotions, pet visits programs. An annu- indicated she was	ticipate her needs and directed issist her to bingo, bible study, s and special musical ial MDS dated 4/22/16, severely cognitively impaired assistance from staff to move	1				
	table alone during	ner wheel chair at the breakfas an observation on 6/2/16, es were closed and her head	t				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00085	B. WING		06/03/2016	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		00/2010
SOOD S	AMARITAN SOCIETY		H STREET			
		WINDOW	I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE ⁻ DATE
2 565	Continued From pa	age 7	2 565			
	finished eating breat the dining table. Sh 9:11 a.m., she was front of the television the right and her ey R50 was still seate unit in front of the t turned on to The P At 11:29 a.m., R50 dining room by state staff member about afternoon after the	arm. At 8:48 a.m. R50 had akfast and continued to sit at ne appeared to be sleeping. At seated in her wheel chair in on. Her head was hanging to yes were closed. At 10:56 a.m. d in the common area of the elevision. The television was rice is Right. R50 was asleep. was escorted to the main ff. R50 was heard asking a tt going outside in the chaplain announced the n., R50 was in bed. She did no activity.				
	nursing assistant (I the unit depended was new to the uni- interests were. NA	v on 6/3/16, at 9:08 a.m., NA)-M stated the activities on on the person. She stated R21 t and she was unsure what her A-M stated R50 did not really sion but would go to bingo				
	stated she worked stated in the mornin residents to sit in fr stated they often sl afternoon the resid would go to the act stated R21 did not would just observe	v on 6/3/16, at 9:58 a.m., AA-A both evenings and days. She ng she would bring the ront of the nird aviary but lept. She stated in the lents watched movies and tivity room for crafts. AA-A participate in the activities and . She stated R46 also went to or crafts but was not able to t observed.				
	director of activities resided on the Cen	v on 6/3/16, at 9:22 a.m., the s (DA) stated the residents who nter unit which included R21, e a calendar with the rest of the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00085	B. WING		06/	03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- WINDOM	H STREET , MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
	impairment. The D. separate activities not put on the cale group programs are in. She stated the a staffed only four da days they can do m resident was asses and if there was a s when cognition or a stated she was una activities each resid could view whether	a they have severe cognitive A stated the facility had for those residents but they are ndar. The AD stated the small e done whenever it can be fit activities department was fully us per week and on those nore. The AD stated each esed upon admission, annually significant change, as well as ability changes. However, she able to determine which dent was participating in, but it was an individual y or a group activity.				
	Plan, and dated Ju policy directed staff care plan that emp development of the the resident receive services. SUGGESTED MET director of nursing meal service to det	I Samaritan Society, Care ne 2012 was reviewed. The f to develop a comprehensive hasizes the care and whole person, ensuring that es appropriate care and THOD OF CORRECTION: The or designee could monitor ermine and establish staffing r of nursing or designee could unce.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty One				
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			7/11/16
	receive nursing car custodial care, and	general. A resident must e and treatment, personal and supervision based on d preferences as identified in				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00085	B. WING		06/03/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 9	2 830			
	plan of care as des 4658.0405. A nurs of bed as much as written order from t	e resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a the attending physician that the ain in bed or the resident n bed.				
	by: Based on observat review, the facility f morning routines in 10 residents (R18, R46, R50, R56, R6 impaired and requi complete activities addition, the facility services in a dignifi	ent is not met as evidenced ion, interview and document failed to provide rising and a dignified manner for 10 of R21, R24, R34, R42, R43, 65), who were cognitively red extensive assistance to of daily living (ADLs). In a failed to provide care and ied and respectful manner for npaired resident (R12) /.		Acknowledged		
	Findings include:					
	limited physical mo assist with dressing and transfers using assistance of two s	ted 9/28/15, indicated she had bility and directed staff to g, grooming, personal hygiene, g a mechanical stand lift with staff. R18's quarterly Minimum ted 3/11/16, indicated she was y impaired.				
	required extensive directed staff to ass and personal hygie	ted 9/1/15, indicated she assist for all ADL's and sist with dressing, grooming one, and to transfer R21 with a ift if weak. R21's quarterly				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00085	B. WING		06/	06/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET , MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	age 10	2 830				
	MDS dated 3/25/16 cognitively impaired	indicated she was severely d.					
	R21 was sitting in h	ion on 6/3/16, at 8:59 a.m., her wheel chair in the common e was asleep and snoring.					
	was moderately co- decreased ability to understand others. 3/17/16, indicated s related to hemipleg with dressing, groo	dated 3/4/16, indicated she gnitively impaired and a o make herself understood or R24's care plan dated she had limited physical ability ia and directed staff to assist ming, personal hygiene, and techanical stand lift with two					
	R24 was dressed a unit. R24 stated "th	ion on 6/3/16, and 6:19 a.m., and seated at the table on the ey get me up too early." At asleep in a recliner chair in					
	was severely cogni plan dated 2/20/16,	S dated 4/20/16, indicated he tively impaired. R34's care , indicated he required physical grooming and personal pathing.					
		ion on 6/3/16, at 6:33 a.m., Ig down the hall with staff room.					
		on 6/3/16, at 9:12:10 a.m., NA)-M stated she had to wake for his bath.					
	deficit and directed	ted 11/12/15, indicated an ADL staff to assist with all activities ransfer with a total body lift and					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING		06/	06/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		"H STREET 1, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 830	Continued From pa	age 11	2 830				
		staff. R42's quarterly MDS ated she was severely d.					
	required assistance transferred using a	ted 4/14/16 indicated she e of two staff for all ADL's and a total body lift. R43's quarterly indicated she was severely d.					
	R43 was in bed. SI	tion on 6/3/16, at 6:43 a.m., he was fully dressed and lying I. R43 was sleeping.					
	deficit related to he assist with dressing and transfer with a staff. R46's quarter	ted 5/14/15, indicated an ADL emiplegia and directed staff to g, grooming, personal hygiene total body lift and assist of two rly MDS dated 4/1/16, indicated cognitively impaired.					
	deficit related to we assist with dressing transfer using a tot staff. R50's Annual	ted 4/7/14 indicated an ADL eakness and directed staff to g, grooming, hygiene and al body lift and assist of two MDS dated 4/22/16, indicated cognitively impaired.					
	R50 was up in her During an observat	tion on 6/3/16, at 6:57 a.m., wheel chair and dressed. tion on 6/3/16, at 7:40 a.m., her wheel chair, sleeping in on.					
	stated she had to v	v on 6/3/16, at 7:00 a.m., NA-C vake R50 up and get her she ate breakfast at 8:00 a.m.					
		ted 3/20/14 indicated an ADL d directed staff to assist with al	1				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00085	B. WING		06/	03/2016
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- WINDOM	H STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	ge 12	2 830			
		ing. R56's quarterly MDS ated moderate cognitive				
	self-care deficit and with dressing, groo	ted 2/29/16, indicated an ADL d directed staff to assist her ming and transfers. R65's cated she was severely d.				
	document titled NC posted at the cente document indicated R56 620am, R20- 6	ion on 5/31/16, at 5:51 p.m., a PC (overnight) gets up was r nurse's station. The the following: "R21- 6am, 640am and R34 7am. Two wo additional residents."				
	dated 6/3/16, listed marks next to their names. A review of	y document labeled, Center, ten residents with check names and six additional a facility document titled 11-7, In AM, and dated 5/23/16,				
	stated she gets res if the call light was She stated, "I don't get residents wash bed." NA-B further	on 6/3/16, at 6:13 a.m., NA-B idents up for the day based on going off and who gets a bath. like to disturb anyone, so I will ed, dressed, and leave them in stated the residents ate at s are a priority and then two				
	stated she worked she had a list of six up in the morning. I them up to get then	on 6/3/16, at 6:45 a.m., NA-C the overnight shift. She stated residents that she had to get NA-C stated, "I have to wake n dressed and washed and in tarting at 5:00 a.m. "				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00085	B. WING		06/	03/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET , MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	During an interview stated she worked i had a list of residen morning. She stated get up eight people stated they have to for the day. NA-N fu people up to get the During an interview registered nurse (R people the night shi how many staff are letting residents sle RN-B stated she wa residents up to get During an interview stated the list of wh who was awake. Sh night shift staff resid one with dressing a arrived to work at 5 unaware staff were them ready for the o practice we encoura During an interview director of nursing (has a list of residen early. She stated th responsible for who between the nurse charge nurse they s She stated if a resid staff may get them back into bed. The	on 6/3/16, at 7:05 a.m., NA-N the night shift. She stated she its she had to get up in the d if there are two staff on they starting around 5:00 a.m. She be ready before she leaves urther stated, "We wake em dressed." on 6/3/16, at 7:09 a.m., N)-B stated the number of ift gets up varies depending on on. She stated staff should be ep unless they are a fall risk. as not aware staff were waking them ready for the day. on 6/3/16, at 7:17 a.m., RN-D o gets up early was based on he stated she tried to give the dents who require assist of nd transfers. RN-D stated she :30 a.m., but she was waking up residents to get day and stated, "It is not a age." on 6/3/16, at 7:46 a.m., the DON) stated the night shift ts at each station who get up e nurse manager was o was on each list and stated managers and the overnight set a list which seems realistic. dent was cognitively impaired up and dressed and put them DON stated the overnight onitoring staff to see if they are				

TATEMENT	Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		E SURVEY PLETED
		00085	B. WING		06/	03/2016
AME OF PR	OVIDER OR SUPPLIER		TADDRESS, CITY, S	TATE, ZIP CODE		00/2010
OOD SAI	MARITAN SOCIETY		XTH STREET OM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
E sessrit Fision Fibble	tated she typically every day. She stat to they can get to b not been told she s hey were ready to R12's face sheet id 3/30/12, with diagnal lepression, anxiety R12's care plan dat behavior symptoms behavioral disturba E/B [evidenced by] efused meds or hic houghts about beir occasionally] holler taff's attention to b interventions identi Behavior #2- repeat holuded "meet resi inable to assist import to assisted as soon o wait." Review of R12's Sin Assessment dated isevere cognitive imple pendent upon fact and activities of dai On 5/31/16, at 4:58 her wheelchair in th	y on 6/3/16 at 9:12 a.m., NA- woke up several residents ted she had to wake them up preakfast. She stated she ha should let residents sleep unt get up. lentified an admission date of oses that included dementia y and delusional disorders. ted 4/22/16 indicated R12 "h s r/t [related to] dementia wit unce and depressive disorde hx [history] of res [resident] des them d/t paranoid ng poisoned and she occ. rs out obscenities to summo be escorted to the bathroom. fied on the care plan under ated bathroom requests" ident's needs promptly. If mediately, hand her written that she will be assisted to assure her often that she wil n as possible if she is having gnificant Change MDS 4/29/16, indicated R12 had npairment and was totally cility staff for personal cares ily living. B p.m. R12 was observed in he hallway between the nurs hroom yelling "I have to pee'	es			
		ctical nurse (LPN)-B then				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
	00085 B. WING			06/03/20			
NAME OF F	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
GOOD S	AMARITAN SOCIETY	- WINDOM					
(X4) ID	SUMMARY STA		, MN 56101	PROVIDER'S PLAN OF	COBBECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET DATE	
2 830	Continued From pa	age 15	2 830				
	began to yell at R12 assistant (AA)-B "H need two people to have anyone else." past LPN-B and int grab out toward LP resident "Don't you continued to try to g bathroom stating, " go, I have to pee." but I don't have any to "get help" and A/ R12 then grabbed I began to yell in R2 ⁻ ouch, ouch" while t R12's grasp. Anoth directly toward R12 to R12 she was "he bathroom." R12 let calm and was assis was not observed t she would be assis LPN-B was intervie regarding the incide LPN-B stated R20 quickly and was gra	ront of the bathroom door and 2 while pointing at an activity le can't use the machine, we use the machine and we don't R12 then attempted to get o the bathroom. R12 began to N-B. LPN-B yelled at the hit me, my dear." R12 get past LPN-B into the I have to pee, that's where I LPN-B stated "I know [R12] y help." LPN-B directed AA-B A-B left the memory care unit. LPN-B's arm and LPN-B 12s face "ouch, ouch, ouch, rying to remove her arm from er NA entered the unit, went and LPN-B and stated calmly ere to help [R12] to the go of LPN-B's arm, appeared sted to the bathroom. LPN-B o write R12 a note of when ted to the bathroom.					
	6/2/16, at 12:00 p.r of behaviors and st on a toileting plan a regarding what time	nurse manager RN-C on n. revealed R12 had a history aff was directed to keep R12 and hand notes to her e she would be assisted to the					
	staff to walk away f if R12 was being pl	ated that she would expect from R12 and reapproach later hysically aggressive towards ed staff have been trained to					

	IT OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00085	B. WING		06/	03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 16	2 830			
		who have behaviors and taff to treat R12 in a				
	6/2/16, at 1:00 p.m training on how to o dementia and beha she expected staff residents and act ir	sing (DON) was interviewed or . and stated all staff receive care for residents with aviors. The DON further stated to follow the care plan for all n a professional and en with residents who exhibit				
	Resident Dignity, d reviewed. The polic maintaining the dig	d Good Samaritan Society ated February 2013, was by indicated a purpose of nity of all residents and to ng and abiding by resident				
	The director of nurs review and revise p to ensuring that res dignified manner. designee could dev and develop a mon	THOD OF CORRECTION: sing (DON) or designee could policies and procedures related sidents are treated in a The director of nursing or velop a system to educate staf itoring system to ensure staff in a dignified manner.				
	TIME PERIOD FOI (21) days	R CORRECTION: Twenty-one				
21435	MN Rule 4658.090 Recreation Program	0 Subp. 1 Activity and n; General	21435			7/11/16
	home must provide recreation program	al requirements. A nursing a norganized activity and . The program must be vidual resident's interests,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00085	B. WING		06/	03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET M, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
21435	Continued From pa	age 17	21435				
	meet the physical, well-being of each comprehensive res comprehensive pla 4658.0400 and 46 provided opportunit	ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ties to participate in the opment of the activity and	Ð				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to provide consistent ng for 3 of 4 residents (R21, d for activities.		Acknowledged			
	Findings include:						
		n a recliner chair in front of th observation on 6/1/16, at	e				
	R21 was sleeping i the unit. Activity sta other residents in th R21 was sitting in h area of the facility. television but R21 w program. At 12:40 common area of th wheel chair in front engaged in the pro- television remained sat in her wheel cha- her shirt. At 1:45 p.	tion on 6/2/16, at 9:09 a.m., n a recliner in the day room o off were providing manicures to he activity room. At 10:56 a.m. her wheel chair in the common The Price is Right was on the was not engaged in the p.m., R21 was assisted to the e unit by staff. She sat in her of the television and was not gram. At 1:03 p.m., the d on in the common area. R21 air playing with the buttons or m., R21 was sitting in a common area. An outside	o ,, 1				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED			
		00085	B. WING		06/03/2016				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•				
GOOD SAMARITAN SOCIETY - WINDOM 705 SIXTH STREET WINDOM, MN 56101									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE			
21435	Continued From pa	age 18	21435						
	attend.								
	R21 was sitting in I area of the unit. Sh 9:57 a.m., R21 was the unit, in front of	tion on 6/3/16, at 8:59 a.m., her wheel chair in the common he was asleep and snoring. At is seated in the front lobby of a bird cage with activity and three other residents. R21 wheel chair.							
	7/10/15, indicated l gardening, singing religious activities a document titled Be directed staff to inv	Data Collection Tool dated R21's interests included , movies, bingo, puzzles, and word games. A facility dside Kardex Report, undated rite R21 to food related food, beverage of choice, and	,						
	dependent on staff stimulation, and so indicated R21's pre-	ted 9/1/15, indicated she was for activities, cognitive cial interaction. The care plan eferred activities included sing, outdoor rides, pet visits radio.							
	3/25/16, indicated s impaired and was t	nimum Data Set (MDS) dated she was severely cognitively totally dependent on staff to ation to another within the unit.							
	nursing assistant (I the unit depended	v on 6/3/16, at 9:08 a.m., NA)-M stated the activities on on the person. She stated R21 t and she was unsure what her							
		v on 6/3/16, at 9:58 a.m., AA-A both evenings and days. She							

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED			
		00085	B. WING		06/03/201				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET									
GOOD SAMARITAN SOCIETY - WINDOM 705 SIXTH STREET WINDOM, MN 56101									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE			
21435	Continued From pa	age 19	21435						
	movies and would g crafts. AA-A stated activities and would stated she had not regarding activities residents. R46 was in a reclin	oon the residents watched go to the activity room for R21 did not participate in the d just observe. AA-A further received any training for cognitively impaired							
	television during ar a.m.	s sleeping in front of the observation on 6/1/16, at 9:24	4						
	R46 was in a reclin area of the unit. Sh television. At 11:36 the facility chaplain reciting a prayer be not in attendance, s dining room on the p.m., R46 was slee reclining wheel cha	ion on 6/2/16, at 9:19 a.m., ing wheel chair in the commor e was sleeping in front of the a.m. in the main dining room, was singing hymns and fore the noon meal. R46 was she was sitting in the small unit she resides on. At 12:09 eping in her room in her ir, at 1:47 p.m., staff put her in tend the outside activity at							
	R46 was sitting in h	ion on 6/3/16, at 9:57 a.m., her wheelchair in the front ility sitting in front of the bird leep.							
	1/30/13, indicated I	Data Collection Tool, dated R46's interests included bingo, ws, quilting and sewing, and animals.							
	was severely cogni dependent on staff	S dated 4/1/16, indicated she tively impaired and totally for all activities of daily living. d 5/14/16, indicated impaired							

ID PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	00085	B. WING		06/	03/2016
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AMARITAN SOCIETY	- WINDOM				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
Continued From pa	ge 20	21435			
her needs and direct	cted staff to invite and assist				
undated, directed s candy bar and drink	taff to visit with R46 with a four to seven times per week				
stated R46 went to	the activity room for crafts but				
table alone during a 7:26 a.m. her eyes was resting on her a finished eating brea the dining table. Sh 9:11 a.m., she was front of the television the right and her ey R50 was still seated unit in front of the te turned on to The Pr At 11:29 a.m., R50 dining room by staff staff member about afternoon after the activity. At 1:49 p.m.	an observation on 6/2/16, at were closed and her head arm. At 8:48 a.m. R50 had akfast and continued to sit at e appeared to be sleeping. At seated in her wheel chair in on. Her head was hanging to res were closed. At 10:56 a.m. d in the common area of the elevision. The television was ice is Right. R50 was asleep. was escorted to the main f. R50 was heard asking a t going outside in the chaplain announced the a., R50 was in bed. She did no				
required staff to ant staff to invite and as	icipate her needs and directed ssist her to bingo, bible study,				
	AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L: Continued From part thought processes her needs and direct her to bingo, outdoor and bible study. A facility document undated, directed s candy bar and drink and invite her to food During an interview stated R46 went to was not able to part R50 was sitting in he table alone during a 7:26 a.m. her eyes was resting on her finished eating breat the dining table. Sh 9:11 a.m., she was front of the television the right and her ey R50 was still seated unit in front of the tel unit of the television the right and her ey R50 was still seated unit in front of the television the right and her ey R50 was still seated unit in front of the television the right and her ey R50 was still seated unit in front of the television the right and her ey R50 was still seated unit in front of the television the right and her ey R50 was still seated unit in front of the television the right and her ey R50 was still seated unit in front of the television the right and her ey R50 was still seated unit in front of the television the right and her ey R50 was still seated unit in front of the television the right and her ey R50 was still seated unit in front of the television the right and her ey R50's care plan data required staff to and staff to invite and as devotions, pet visits	OF CORRECTION IDENTIFICATION NUMBER: 00085 00085 PROVIDER OR SUPPLIER STREET A AMARITAN SOCIETY - WINDOM TOS SIXT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 Continued From page 20 thought processes and inability to communicate her needs and directed staff to invite and assist her to bingo, outdoor time, happy hour, worship, and bible study. A facility document titled Bedside Kardex Report, undated, directed staff to visit with R46 with a candy bar and drink four to seven times per week and invite her to food related activities. During an interview on 6/3/16, at 9:58 a.m. AA-A stated R46 went to the activity room for crafts but was not able to participate, she just observed. R50 was sitting in her wheel chair at the breakfas table alone during an observation on 6/2/16, at 7:26 a.m. her eyes were closed and her head was resting on her arm. At 8:48 a.m. R50 had finished eating breakfast and continued to sit at the dining table. She appeared to be sleeping. At 9:11 a.m., she was seated in her wheel chair in front of the television. Her head was hanging to the right and her eyes were closed. At 10:56 a.m. R50 was still seated in the common area of the unit in front of the television. The television was turned on to The Price is Right. R50 was asleep. At 11:29 a.m., R50 was escored to the main dining room by staff. R50 was heard asking a staff member about going outside in the afternoon after the chaplain announced the activity. At 1:49 p.m., R50 was in bed. She did no attend the outside activity.	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00085 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST AMARITAN SOCIETY - WINDOM 705 SIXTH STREET WINDOM, MN 56101 Image: Comparison of the compari	OF CORRECTION IDENTIFICATION NUMBER: 00085 A. BUILDING: B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AMARITAN SOCIETY - WINDOM TOS SIXTH STREET WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIND BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) (EACH DEFICIENCY WINDOM) Continued From page 20 21435 CROSS-REFERENCED TO T DEFICIENCY CROSS-REFERENCED TO T DEFICIENCY Continued From page 20 21435 CROSS-REFERENCED TO T DEFICIENCY DEFICIENCY WINDOM Continued From page 20 21435 CROSS-REFERENCED TO T DEFICIENCY DEFICIENCY Continued From page 20 21435 CROSS-REFERENCED TO T DEFICIENCY DEFICIENCY WINDOM Continued From page 20 21435 CROSS-REFERENCED TO T DEFICIENCY DEFICIENCY Continued From page 20 21435 CROSS-REFERENCED TO T DEFICIENCY DEFICIENCY Continued From page 20 21435 State Hacting and think four to serve times per week and invite her to food related activities. During an interview on 6/3/16, at 9:58 a.m. AA-A	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00085 B. WING 066/ MARITAN SOCIETY - WINDOM TOS SIXTH STREET 066/ MARITAN SOCIETY - WINDOM TOS SIXTH STREET PROVIDER'S PLAN OF CORRECTION NUMBER: 0 BEGULATORY ON LGC IDENTIFYING INFORMATION) ID PREVIDENC ON STREET PROPERTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE Continued From page 20 100 PREVIDENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE Continued From page 20 21435 CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE Continued From page 20 100 PREVIDENCE CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE Continued From page 20 21435 CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE Continued From page 20 21435 CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE Continued From page 20 21435 CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE Continued Commentities Continued Staff to invite and assist CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE Continue The tobingo, bio Exercit

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
	PROVIDER OR SUPPLIER	00085	DDRESS, CITY, ST		06/	03/2016
		705 SIXT	TH STREET	ATE, ZIP CODE		
200D S/	AMARITAN SOCIETY	- WINDOM WINDOM	I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21435	Continued From pa	age 21	21435			
	 4/19/16, indicated F singing, discussion and family visits. A Bedside Kardex Re- invite R50 to bingo, entertainment. An annual MDS da severely cognitively assistance from sta to another. During an interview stated R50 did not but would go to bin During an interview director of activities reside on the secur separate calendar who reside on the C R21, R46 and R50 of the facility even to cognitive impairme can be adapted to a have separate activities they are not put on R21 liked music an with sensory object teacher and enjoye group programming. The programs are done 	R50 enjoyed listening to music , exercise, religious activities, facility document titled eport, undated, directed staff to , bible study, and musical ted 4/22/16, indicated she was / impaired and required total aff to move from one location / on 6/3/16, at 9:10 a.m., NA-M really like to watch television				
		week and on those days they				
	registered nurse (R	v on 6/3/16, at 9:34 a.m., RN)-B stated there was a for cognitively impaired				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00085	B. WING		06/03/2016	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET A, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 22	21435			
	checks with them." what R50 liked to c	hit. She stated, "I think activities She stated she was unsure of lo, stated she thought R21 and stated R46 likes to spend	f			
	cognitively impaired indicated small gro these residents, the activities designed residents who were	ation of the facility had multiple d residents, and while the AD up activities were done with ere was no evidence of for cognitively impaired e dependent on staff for activity sided outside the secured				
	Guidelines In Prog Unit Resident, and reviewed. The polic daily or monthly ca the current abilities	A Samaritan Society, ramming For The Special Care dated August 2012 was by directed staff to develop a lendar of events according to of the residents. The policy ff to provide activities each and evening.	9			
	The activity directo systems of ensurin cognitively impaired Director could educ	THOD FOR CORRECTION: r or designee could develop g activity programming for d residents. The Activity cate all appropriate staff and systems to ensure ongoing				
	TIME PERIOD FO Twenty-One (21) d					
21610	MN Rule 4658.134 and Preparation Ar	0 Subp. 1 Medicine Cabinet ea;Storage	21610			7/11/16

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00085	B. WING		06/03/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- WINDOM	H STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	
21610	Continued From pa	ge 23	21610			
	under proper tempe	s in locked compartments erature controls, and permit sing personnel to have				
	by: Based on observati review, the facility f were securely store reviewed. In additio	ent is not met as evidenced ion, interview and document ailed to ensure medications ed for 1 of 1 resident (R20) on, the facility failed to ensure ts (cart on 200 wing) was ed.		Acknowledged		
	Findings include:					
	an observation was unit of medications medication cart. A cup with crushed m sitting on the medic bottles of liquid Gat	n 4:58 p.m. through 5:04 p.m. s made on the memory care being stored on the clear, non-labeled, medication hedications in it was observed cation cart as well as two large papentin 250 mg/ml) with R20's name on the				
	at 5:04 p.m. LPN-B clear medication cu there were crushed including Levothyro Digoxin (regulates t	hurse (LPN)-B was interviewed confirmed she had left the up on top of the cart and stated medications in the cup exine (thyroid medication) and the heart). In addition, LPN-B abapentin bottles had been lef				
	Gabapentin continuside of the medicat was "going on brea	1/16, the two bottles of led to be observed on the left ion cart. LPN-B stated she k" and locked the medication pserved to move the two				

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00085	B. WING		06/	06/03/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE	
21610	Continued From pa	age 24	21610				
	bottles of Gabapen of the cart and walk	tin to the right side of the top ked away.					
	cart from 4:58 p.m. two bottles of Gaba medication cart. At	observation of the medication until 6:10 p.m. on 5/31/16, the apentin remained on top of the 6:10 p.m., LPN-B returned had left the Gabapentin on the					
	6/2/16, at 11:50 a.n Gabapentin should the medication cart expect staff to pour	sing (DON) was interviewed or n. The DON verified R20's not have been left on top of t. The DON said she would r out the dosage of medication put the bottle back in the vas secured.					
	(a nurse from the 2 unlock a medication top while looking fo then shut the medic in, and proceeded a the hallway to give lock the cart, nor pi walking away from unlocked medication time, the surveyor a away from the cart keys on top. RN-C question with "uh." medication cart, it w	a.m. registered nurse (RN)-C 200 unit) was observed to n cart, and place her keys on or eye drops for R15. RN-C cation drawer she was looking around the corner and down R15 eye drops. RN-C did not ick up her cart keys prior to the cart. RN-C returned to the on cart at 9:39 a.m. At that asked RN-C about walking which was unlocked and had only acknowledged the During review of the was noted to contain insulin us oral medications for					
	DON verified she'd	th the DON at 3:30 p.m., the been made aware RN-C had cart unlocked with the keys on					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00085	B. WING	B. WING		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	age 25	21610			
	be kept locked and	ied the medication cart should the keys should be kept with sible for passing medications.				
	Dispensing and Sto 12/15, indicated: "n locked medication the person passing director of nursing	ntitled Acquisition, Receiving, orage of Medications dated nedication will be stored in a cart, drawer or cupboard. Only the medications and the services will be permitted to keys to the medications				
	administrator, direct consulting pharmace policies and procect medications. Nursin necessary to the im medications. The D	THOD OF CORRECTION: The stor of nursing (DON) and cist could review and revise dures for proper storage of ng staff could be educated as nportance of properly securing DON or designee, along with uld conduct audits on a regular mpliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one				
21685	MN Rule 4658.141 Housekeeping, Op	5 Subp. 2 Plant eration, & Maintenance	21685			7/11/16
	including walls, floc systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation health, comfort, safety, and esidents according to a written be and repair program.				
	This MN Requirem	ent is not met as evidenced				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING		06/	06/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE			
GOOD SA	AMARITAN SOCIETY	- WINDOM	IXTH STREET OM, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21685	Continued From pa	age 26	21685				
	review, the facility f equipment in a clea promote sanitation kitchen. This practi	ion, interview and documen ailed to maintain kitchen an and sanitary manner to and food safety in the main ce had the potential to affec o received food from the		Acknowledged			
	Findings include:						
	the following sanita	tour on 5/31/16, at 12:20 p.r tion concerns were observe he Director of Dietary (DD):					
	handle on the oven brown/black substa	stove, all six knobs and long were sticky with a buildup of ance on and around the kno e was cleaned after each m	of a bs.				
		at top griddle were dirty and p of a brown/black substan					
		kitchen tour on 6/2/16, at 1: canitation concerns were ied by the DD:	25				
	grates had a buildu debris in the corner each set of grates. situated below the s splatter down the fr and food debris cal of the handle. All si	ove with three sets of two up of a greasy black food rs of the grates and between The outside of the oven doo stove burner stove had food ront of it and there was grea ked on and around the corn x knobs had a heavy buildu stance on and around the	or I se ers				
		e front plate was covered w asy residue with food spills	ith				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION I			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00085		B. WING		06/	06/03/2016	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		00/2010	
GOOD S	AMARITAN SOCIETY	- WINDOM		H STREET MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC / MUST BE PRECEDED I SC IDENTIFYING INFOR	VIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
21685	Continued From pa	ge 27		21685				
	down the front pane units needed clean cleaning schedule, units were schedule	ing and although th she was not sure i ed for deep cleanin	ney have a f the two Ig.					
	During an interview stated the deep cle the cleaning duty lis the deep cleaning of effect prior to surve	aning of the stove at "but it is now." Di duties was the polic	was not on D verified					
	Review of the unda policy did not includ griddle or the six bu	le cleaning of eithe						
	Review of the unda policy indicated the cleaning the "grill" a responsible for clea stove top area."	AM cook was resp and the PM cook w	onsible for as					
	The DON or designed dietary staff to concern residents frequent to functional and hom maintained to the e	duct periodic audits to ensure a safe, cl elike environment	of areas lean,					
	SUGGESTED MET administrator could cleaning of kitchen keep it clean and se	in-service employe equipment on the	ees who do					
	Time period for cor	rection: Twenty one	e (21) days.					
21805	MN St. Statute 144 Residents of HC Fa		nts &	21805			7/11/16	
	Subd. 5. Courteo residents have the	us treatment. Patie						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING		06/	06/03/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		TH STREET M, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	lge 28	21805				
		ct for their individuality by rsons providing service in a					
by Ba rev 10 R4 im co ad se 1 c rev Fir R1 lim as an as Da	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide rising and morning routines in a dignified manner for 10 of 10 residents (R18, R21, R24, R34, R42, R43, R46, R50, R56, R65), who were cognitively impaired and required extensive assistance to complete activities of daily living (ADLs). In addition, the facility failed to provide care and services in a dignified and respectful manner for 1 of 1 cognitively impaired resident (R20) reviewed for dignity. Findings include: R18's care plan dated 9/28/15, indicated she had		4	Acknowledged			
	limited physical mo assist with dressing and transfers using assistance of two s	bility and directed staff to g, grooming, personal hygiene a mechanical stand lift with taff. R18's quarterly Minimum ted 3/11/16, indicated she was	,				
	required extensive directed staff to ass and personal hygie mechanical stand li	ted 9/1/15, indicated she assist for all ADL's and sist with dressing, grooming ne, and to transfer R21 with a ift if weak. R21's quarterly indicated she was severely d.					
	R21 was sitting in h	ion on 6/3/16, at 8:59 a.m., her wheel chair in the commor e was asleep and snoring.	1				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00085	B. WING		06/	03/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		TH STREET 1, MN 56101			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC		(X5) COMPLET DATE
21805	Continued From pa	age 29	21805			
	was moderately co decreased ability to understand others. 3/17/16, indicated s related to hemipleg with dressing, groo	dated 3/4/16, indicated she ognitively impaired and a o make herself understood or R24's care plan dated she had limited physical ability gia and directed staff to assist oming, personal hygiene, and nechanical stand lift with two				
	R24 was dressed a unit. R24 stated "th	tion on 6/3/16, and 6:19 a.m., and seated at the table on the ney get me up too early." At s asleep in a recliner chair in				
	was severely cogni plan dated 2/20/16	DS dated 4/20/16, indicated he itively impaired. R34's care , indicated he required physica , grooming and personal bathing.	l			
		tion on 6/3/16, at 6:33 a.m., ng down the hall with staff room.				
		v on 6/3/16, at 9:12:10 a.m., NA)-M stated she had to wake < for his bath.				
	deficit and directed of daily living and the assistance of two s	ted 11/12/15, indicated an ADL I staff to assist with all activities ransfer with a total body lift and staff. R42's quarterly MDS ated she was severely d.	6			
		ted 4/14/16 indicated she e of two staff for all ADL's and				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00085	B. WING		06/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET M, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 30	21805			
		total body lift. R43's quarterly indicated she was severely d.				
	During an observation on 6/3/16, at 6:43 a.m., R43 was in bed. She was fully dressed and lying on top of a lift sling. R43 was sleeping.					
	deficit related to he assist with dressing and transfer with a staff. R46's quarter	ted 5/14/15, indicated an ADL miplegia and directed staff to g, grooming, personal hygiene total body lift and assist of two ly MDS dated 4/1/16, indicated ognitively impaired.				
	deficit related to we assist with dressing transfer using a tot staff. R50's Annual	ted 4/7/14 indicated an ADL eakness and directed staff to g, grooming, hygiene and al body lift and assist of two MDS dated 4/22/16, indicated ognitively impaired.				
	R50 was up in her During an observat	ion on 6/3/16, at 6:57 a.m., wheel chair and dressed. ion on 6/3/16, at 7:40 a.m., her wheel chair, sleeping in on.				
	stated she had to v	on 6/3/16, at 7:00 a.m., NA-C vake R50 up and get her he ate breakfast at 8:00 a.m.)			
	self-care deficit and activities of daily liv	ted 3/20/14 indicated an ADL d directed staff to assist with al ing. R56's quarterly MDS ated moderate cognitive	I			
		ted 2/29/16, indicated an ADL d directed staff to assist her				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			E SURVEY PLETED
		00085	B. WING		06/	03/2016
AME OF F	PROVIDER OR SUPPLIER	I	DDRESS, CITY, S	TATE, ZIP CODE		00/2010
		705 SIXT	'H STREET			
1000 5	AMARITAN SOCIETY	WINDOM WINDOM	I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21805	Continued From pa	age 31	21805			
	with dressing, grooming and transfers. R65's quarterly MDS indicated she was severely cognitively impaired.					
	document titled NC posted at the cente document indicate R56 620am, R20-	tion on 5/31/16, at 5:51 p.m., a DC (overnight) gets up was er nurse's station. The d the following: "R21- 6am, 640am and R34 7am. Two two additional residents."				
	dated 6/3/16, listed marks next to their names. A review o	y document labeled, Center, d ten residents with check names and six additional f a facility document titled 11-7 o In AM, and dated 5/23/16,				
	stated she gets res if the call light was She stated, "I don't get residents wash bed." NA-B further	v on 6/3/16, at 6:13 a.m., NA-B sidents up for the day based or going off and who gets a bath. t like to disturb anyone, so I wil ned, dressed, and leave them ir r stated the residents ate at ts are a priority and then two				
	stated she worked she had a list of six up in the morning. them up to get the	v on 6/3/16, at 6:45 a.m., NA-C the overnight shift. She stated c residents that she had to get NA-C stated, "I have to wake m dressed and washed and in starting at 5:00 a.m. "				
	stated she worked had a list of resider morning. She state get up eight people	v on 6/3/16, at 7:05 a.m., NA-N the night shift. She stated she nts she had to get up in the ed if there are two staff on they e starting around 5:00 a.m. She b be ready before she leaves				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00085	B. WING		06/	03/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- WINDOM	H STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 32	21805			
	for the day. NA-N for people up to get the	urther stated, "We wake em dressed."				
	registered nurse (R people the night sh how many staff are letting residents sle RN-B stated she w	on 6/3/16, at 7:09 a.m., N)-B stated the number of ift gets up varies depending or on. She stated staff should be eep unless they are a fall risk. as not aware staff were waking them ready for the day.)			
	stated the list of wh who was awake. Sl night shift staff resi one with dressing a arrived to work at 5 unaware staff were	on 6/3/16, at 7:17 a.m., RN-D to gets up early was based on the stated she tried to give the dents who require assist of and transfers. RN-D stated she 5:30 a.m., but she was waking up residents to get day and stated, "It is not a age."				
	director of nursing has a list of resider early. She stated the responsible for who between the nurse charge nurse they s She stated if a resident staff may get them back into bed. The	y on 6/3/16, at 7:46 a.m., the (DON) stated the night shift its at each station who get up he nurse manager was o was on each list and stated managers and the overnight set a list which seems realistic dent was cognitively impaired up and dressed and put them DON stated the overnight ponitoring staff to see if they are p.				
	stated she typically every day. She stat so they can get to b	on 6/3/16 at 9:12 a.m., NA-M woke up several residents ted she had to wake them up preakfast. She stated she had hould let residents sleep until get up				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED	
		00085	B. WING		06/	06/03/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
	AMARITAN SOCIETY	705 SIXT	H STREET				
		WINDOM	, MN 56101			- 1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACT		(X5) COMPLET DATE	
21805	Continued From pa	age 33	21805				
	R20's face sheet identified an admission date of 3/30/12, with diagnoses that included dementia, depression, anxiety and delusional disorders.						
	R20's care plan dated 4/22/16 indicated R20 "has behavior symptoms r/t [related to] dementia with behavioral disturbance and depressive disorder E/B [evidenced by] hx [history] of res [resident] refused meds or hides them d/t paranoid thoughts about being poisoned and she occ. [occasionally] hollers out obscenities to summon staff's attention to be escorted to the bathroom." Interventions identified on the care plan under "Behavior #2- repeated bathroom requests" included "meet resident's needs promptly. If unable to assist immediately, hand her written note the exact time that she will be assisted to the bathroom next. Reassure her often that she will be assisted as soon as possible if she is having to wait."						
	Assessment dated severe cognitive im	gnificant Change MDS 4/29/16, indicated R20 had pairment and was totally cility staff for personal cares ily living.					
	her wheelchair in the station and the bath while running her w door. Licensed prace stood over R20 in f began to yell at R20	8 p.m. R20 was observed in the hallway between the nurses hroom yelling "I have to pee" wheelchair into the bathroom ctical nurse (LPN)-B then front of the bathroom door and 0 while pointing at an activity le can't use the machine, we					
	need two people to have anyone else." past LPN-B and int	use the machine and we don't R20 then attempted to get o the bathroom. R20 began to N-B. LPN-B yelled at the					

<u>/innesota De</u> TATEMENT OF I ND PLAN OF CC				(X3) DATE SURVEY COMPLETED		
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IAME OF PROVID	DER OR SUPPLIER	STREET #	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD SAMA	RITAN SOCIETY	- WINDOM	TH STREET M, MN 56101			
(X4) ID PREFIX TAG I	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
resid conti bath go, I but i to "g R20 bega oucl R20 direct to R bath calm was she LPN rega LPN quice hand her. Inter 6/2/ of b on a rega bath staff if R2 staff work	tinued to try to g room stating, " I have to pee." I don't have any get help" and Av then grabbed an to yell in R20 h, ouch" while t 's grasp. Anoth ctly toward R20 20 she was "he for and was assis not observed t would be assis I-B was intervie arding the incide I-B stated R20 kly and was gra ds." LPN-B stat " rview with the n 16, at 12:00 p.r ehaviors and stat toileting plan a arding what time for walk away f 20 was being pl f. RN-C indicat k with residents id not expect si heaning manor.	hit me, my dear." R20 get past LPN-B into the I have to pee, that's where I LPN-B stated "I know [R20] y help." LPN-B directed AA-B A-B left the memory care unit. LPN-B's arm and LPN-B 0's face "ouch, ouch, ouch, rying to remove her arm from the NA entered the unit, went 0 and LPN-B and stated calmly ere to help [R20] to the go of LPN-B's arm, appeared sted to the bathroom. LPN-B o write R20 a note of when the that occurred with R20. became "very agitated, very abbing me by the wrists and ted "this happens a lot with hurse manager RN-C on n. revealed R20 had a history taff was directed to keep R20 and hand notes to her e she would be assisted to the ated that she would expect from R20 and reapproach late hysically aggressive towards ted staff have been trained to s who have behaviors and taff to treat R20 in a	/ * r			
trair		and stated all staff receive care for residents with				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00085	B. WING		06/	03/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
iood s	AMARITAN SOCIETY		TH STREET A, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21805	Continued From pa	age 35	21805			
	she expected staff residents and act in	aviors. The DON further stated to follow the care plan for all n a professional and en with residents who exhibit				
	Resident Dignity, d reviewed. The polic maintaining the dig	d Good Samaritan Society lated February 2013, was cy indicated a purpose of inity of all residents and to ing and abiding by resident				
	The DON or design dignity and respect then interview resid	THOD OF CORRECTION: nee could educate staff on the DON or designee could dents routinely to ensure dignity and respect are being				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty One	•			
21810	MN St. Statute 144 Residents of HC F	.651 Subd. 6 Patients & ac.Bill of Rights	21810			7/11/16
	residents shall hav medical and person needs. Appropriate care designed to e highest level of phy This right is limited	riate health care. Patients and e the right to appropriate nal care based on individual e care for residents means nable residents to achieve thei vsical and mental functioning. where the service is not ublic or private resources.				
	This MN Requirem by:	ent is not met as evidenced				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00085	B. WING	(06/03/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE	
21810	Continued From pa	ige 36	21810				
	Based on observation, interview and document review the facility failed to ensure 1 of 1 resident (R49) who was identified at being at risk for falls had a call light within reach. Findings include:			Acknowledged			
	admission diagnosi emboli (blood clot in the Admission Face intact cognition, and R49 required exten bed mobility, transfa able demonstrate un request. The Care R49 was dependen able to call for assis undated Visual/Bec "Resident is able to pain."	to the facility 2/3/12, with is of heart failure, deep vein in legs), and hypertension per e Sheet. R49 had moderately d did not exhibit any behaviors sive assistance of two staff for ers, and toilet use. R49 was use of her call light upon Plan dated 3/17/16, identified at on staff for cares and was stance using the call light. The Iside Kardex report indicated o call for assistance when in					
	observed and interv not within reach. R4 wheelchair with a tr the wheel chair was to the recliner, and on the far side of th	a.m. resident R49 was viewed and the call light was 49 was sitting in her ray table attached (for crafts), s sitting at a 45 degree angle the call light was on the floor re recliner. R49 asked to have d to her, she was then able to and it did function.					
	(DON) verified R49 it should have been -At 12:22 p.m. the r "Even I was taught room, you give ther	a.m. the Director of Nursing can use her call light, and that within reach. maintenance man stated, that if you take a patient into a m the call light, or if you stop in the call light, you give it to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00085	B. WING		06 /	03/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From pa	age 37	21810			
	directed: "Purpose: To ensur method of calling fo "Procedure: 3. Who light within easy rea	en leaving the room, place call ach of resident if in bed. If out light cord across bed so				
	The director or main could develop system light use which include testing of call light could educate all a	THOD FOR CORRECTION: intenance (DM) or designee ems of ensuring consistent cal uded the routine random function. The DM or designee ppropriate staff. The DM could systems to ensure ongoing				
	TIME PERIOD FO Twenty-One (21) d					
23010	MN Rule 4658.463 Construction	5 A Nurse Call System; New	23010			7/11/16
	communication sys from the resident a required by this par system, if electrical connected to the en Nurse calls and em of being inactivated central annunciator	a must be equipped with a stem designed to receive calls and nursing service areas rt. The communication lly powered, must be mergency power supply. hergency calls must be capable d only at the points of origin. A r must be provided where the rom the nurses' station.				
	resident's bed. Ca	must be provided for each Il cords, buttons, or other vices must be placed where				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X3)	(X3) DATE SURVEY COMPLETED	
		00085	B. WING		06/03/2016	
IAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- WINDOM	TH STREET M, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
23010	Continued From pa	ige 38	23010			
	from a resident mu station, activate a li bedroom, and activ medication room, n room, soiled utility multi-corridor nursi	ch of each resident. A call st register at the nurses' ght outside the resident ate a duty signal in the ourishment area, clean utility room, and sterilizing room. In ng units, visible signal lights t corridor intersections.				
	by: Based on observat failed to assure a re	ent is not met as evidenced ion and interview, the facility oom call light was functioning s (R107) residing in the facility		Acknowledged		
	Findings include:					
	The admission Min 5/25/16, identified F impairment, howev for Stage I data. The required two person one person assist f living except eating indicated R107 req bladder/bowel inco falls. The care plan remind the resident	ed to the facility on 5/19/16. imum Data Set (MDS) dated R107 had severe cognitive er was able to be interviewed he MDS indicated R107 in assist for bed mobility and or all other activities of daily . The care plan dated 5/20/16, uired staff assist to manage intinence and was at risk for indicated staff needed to t not to bend over to pick up encourage the use of a assistance.	,			
	room was observed her bed. R107 was bed, was able to id which resulted in it assistant (NA)-A ar	p.m. the call light in R107's d to be pinned to the sheets or sitting up on the edge of the entify and press the call light, being nonfunctional. Nursing d registered nurse (RN)-A t was not functional, with RN- <i>t</i>				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
23010	Continued From pa	age 39	23010		• /	
	stating "I will contact	-				
	During an interview on 6/3/16, at 11:37 a.m. environmental assistant (EA) stated he was notified that the call light did not work on 5/31/16 at which time he replaced it. EA stated he used to check every room quarterly, but the housekeeping supervisor (HS) has been responsible for that since January.					
	stated she conduct functions for each t the resident would functioning. The ca maintenance and t	v on 6/3/16, at 12:03 p.m. HS ts quarterly audits on call light resident and typically a NA or tell maintenance if it wasn't all was logged with he director of maintenance . HS stated EA would have the				
	stated "if staff or ar stated that staff wo Hotline system whi then address it, exc emergency, "we do	y on 6/3/16, at 12:18 p.m. EA hybody tells me I replace it." EA buld call the maintenance ch started in January and we cept if we consider it an b it immediately, like lights." EA verified the facility ren policy.				
	dated September 2 was to ensure resid calling for assistant to report nonfunction METHOD OF COF nursing or designed	ty Procedure for Call Light 2012, indicated the purpose dents always had a method of ce but lacked direction on how oning call lights. SUGGESTED RECTION: The director of e could review and revise the place to ensure resident call ng properly.				
	TIME PERIOD FO (21) days.	R CORRECTION:Twenty One				

STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED	
		00085	B. WING		06/	03/2016
IAME OF P	ROVIDER OR SUPPLIER	STREET.	ADDRESS, CITY, ST	TATE, ZIP CODE		
GOOD SA	MARITAN SOCIET		TH STREET M, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE