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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B617

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245558**

2. STATE VENDOR OR MEDICAID NO. (L2) **677840200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9I)

6.IATEIOFISURVEY **7/18/2016** (L34)

I. ACCREIITATIONISTATUS (L10) ___
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

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

B.IIINotIinICmplianceIwithIProgram Requirements and/or Applied Waivers: * Code: **A*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : Gloria Derfus, Unit Supervisor 7/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 7/28/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **05/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

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,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245558 Y1	A. Building B. Wing Y2	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0246	Correction	ID Prefix F0248	Correction
Reg. # 483.15(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 F0282	Correction	ID Prefix F0373	Correction	ID Prefix F0431	Correction
Reg. # 483.20(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 F0463	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.70(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 STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	7/28/2016	18623	7/18/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
245558	A. Building 01 - MAIN BUILDING 01 B. Wing	7/24/2016

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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 06/29/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 06/29/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B617

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245558**

2. STATE VENDOR OR MEDICAID NO. (L2) **677840200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/03/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : 07/01/2016 (L19)
Carrie Fuerle, HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date: 07/22/2016 (L20)
Kamala Fiske-Downing, Health Program Representative

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **05/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

Remedies - 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;

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

Informal Dispute Resolution - 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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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:

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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	06/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation(s) was also completed at the time of the standard survey. An investigation of complaint H5558011 was not substantiated during this survey.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This 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 7 of 10 residents (R21, R24, R34, R43, R50, R56, R65), who were cognitively impaired and required extensive assistance to complete activities of daily living (ADLs). In addition, the facility failed to	F 241	F-241 Corrected Date: July 11, 2016 It is the current policy and procedure of GSS-Windom to respect all resident rights, including those regarding dignity and preferences.	7/11/16

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

Electronically Signed | 06/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	06/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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F 241	Continued From page 1 provide care and services in a dignified and respectful manner for 1 of 1 cognitively impaired resident (R12) reviewed for dignity. Findings include: R21's care plan dated 9/1/15, indicated she required extensive assist for all ADL's and directed staff to assist with dressing, grooming and personal hygiene, and to transfer R21 with a mechanical stand lift if weak. R21's quarterly MDS dated 3/25/16 indicated she was severely cognitively impaired. 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. R24's annual MDS dated 3/4/16, indicated she was moderately cognitively impaired and a decreased ability to make herself understood or understand others. R24's care plan dated 3/17/16, indicated she had limited physical ability related to hemiplegia and directed staff to assist with dressing, grooming, personal hygiene, and transfers using a mechanical stand lift with two staff. During an observation on 6/3/16, and 6:19 a.m., R24 was dressed and seated at the table on the unit. R24 stated "they get me up too early." At 9:06 a.m., R24 was asleep in a recliner chair in her room. R34's quarterly MDS dated 4/20/16, indicated he was severely cognitively impaired. R34's care plan dated 2/20/16, indicated he required physical assist for dressing, grooming and personal hygiene, including bathing.	F 241	The assessments and care plans of R21, R24, R34, R43, R50, R56, and R65 will be reviewed and updated by the case managers as needed to reflect individual choice in their morning routines by July 1, 2016. All lists were eliminated. Residents, who are cognitively impaired, reside outside of the unit, and require extensive assistance are at risk for similar deficient practices. Their assessments and care plans will be reviewed and updated by the case managers as needed to reflect individual choice in their morning routines, by July 11, 2016. R20□s care plan was reviewed and found to be appropriate by the case manager. Other residents with dementia are at risk for similar deficient practices by this nurse. LPN-B was re-educated regarding dementia, therapeutic ways to interact with residents with dementia, and following care plans on June 6 and 17, 2016 by the Director of Nursing using written and on-line materials. All nursing staff will be re-educated by the Director of Nursing on June 28, 29, and 30, 2016, regarding resident rights, including dignity and respecting preferences of residents and in particular regarding morning routines, as well as following the care plan and therapeutic interventions for persons with dementia. An audit of the morning routines of 2 random residents who are cognitively	

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F 241	Continued From page 2 During an observation on 6/3/16, at 6:33 a.m., R34 was ambulating down the hall with staff toward the shower room. During an interview on 6/3/16, at 9:12:10 a.m., nursing assistant (NA)-M stated she had to wake R34 up every week for his bath. R43's care plan dated 4/14/16 indicated she required assistance of two staff for all ADL's and transferred using a total body lift. R43's quarterly MDS dated 4/1/16, indicated she was severely cognitively impaired. 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. R50's care plan dated 4/7/14 indicated an ADL deficit related to weakness and directed staff to assist with dressing, grooming, hygiene and transfer using a total body lift and assist of two staff. R50's Annual MDS dated 4/22/16, indicated she was severely cognitively impaired. During an observation on 6/3/16, at 6:57 a.m., R50 was up in her wheel chair and dressed. During an observation on 6/3/16, at 7:40 a.m., R50 was sitting in her wheel chair, sleeping in front of the television. During an interview on 6/3/16, at 7:00 a.m., NA-O stated she had to wake R50 up and get her dressed because she ate breakfast at 8:00 a.m. R56's care plan dated 3/20/14 indicated an ADL self-care deficit and directed staff to assist with all activities of daily living. R56's quarterly MDS	F 241	impaired, reside outside of the unit, and require extensive assistance will be conducted by the Director of Nursing or designee, 3x/week for 2 weeks, then 2x/week for 4 weeks, and then monthly x2. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 241	Continued From page 3	F 241		

dated 4/1/16, indicated moderate cognitive impairment.

R65's care plan dated 2/29/16, indicated an ADL self-care deficit and directed staff to assist her with dressing, grooming and transfers. R65's quarterly MDS indicated she was severely cognitively impaired.

During an observation on 5/31/16, at 5:51 p.m., a document titled NOC (overnight) gets up was posted at the center nurse's station. The document indicated the following: "R21- 6 am, R56 620am, R20- 640am and R34 7am. Two night aides get up two additional residents."

A review of a facility document labeled, Center, dated 6/3/16, listed ten residents with check marks next to their names and six additional names. A review of a facility document titled 11-7, List For Getting Up In AM, and dated 5/23/16, listed six names.

During an interview on 6/3/16, at 6:13 a.m., NA-B stated she gets residents up for the day based on if the call light was going off and who gets a bath. She stated, "I don't like to disturb anyone, so I will get residents washed, dressed, and leave them in bed." NA-B further stated the residents ate at 7:30 a.m., call lights are a priority and then two person transfers.

During an interview on 6/3/16, at 6:45 a.m., NA-C stated she worked the overnight shift. She stated she had a list of six residents that she had to get up in the morning. NA-C stated, "I have to wake them up to get them dressed and washed and in their wheel chairs starting at 5:00 a.m. "

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F 241	Continued From page 4 During an interview on 6/3/16, at 7:05 a.m., NA-N stated she worked the night shift. She stated she had a list of residents she had to get up in the morning. She stated if there are two staff on they get up eight people starting around 5:00 a.m. She stated they have to be ready before she leaves for the day. NA-N further stated, "We wake people up to get them dressed." During an interview on 6/3/16, at 7:09 a.m., registered nurse (RN)-B stated the number of people the night shift gets up varies depending on how many staff are on. She stated staff should be letting residents sleep unless they are a fall risk. RN-B stated she was not aware staff were waking residents up to get them ready for the day. During an interview on 6/3/16, at 7:17 a.m., RN-D stated the list of who gets up early was based on who was awake. She stated she tried to give the night shift staff residents who require assist of one with dressing and transfers. RN-D stated she arrived to work at 5:30 a.m., but she was unaware staff were waking up residents to get them ready for the day and stated, "It is not a practice we encourage." During an interview on 6/3/16, at 7:46 a.m., the director of nursing (DON) stated the night shift has a list of residents at each station who get up early. She stated the nurse manager was responsible for who was on each list and stated between the nurse managers and the overnight charge nurse they set a list which seems realistic. She stated if a resident was cognitively impaired staff may get them up and dressed and put them back into bed. The DON stated the overnight nurse should be monitoring staff to see if they are waking residents up.	F 241		

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F 241	Continued From page 5 During an interview on 6/3/16 at 9:12 a.m., NA-M stated she typically woke up several residents every day. She stated she had to wake them up so they can get to breakfast. She stated she had not been told she should let residents sleep until they were ready to get up. R12's face sheet identified an admission date of 3/30/12, with diagnoses that included dementia, depression, anxiety and delusional disorders. R12's care plan dated 4/22/16 indicated R12 "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." Review of R12's Significant Change MDS Assessment dated 4/29/16, indicated R12 had severe cognitive impairment and was totally 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"	F 241		

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F 241	Continued From page 6	F 241		

while running her wheelchair into the bathroom door. Licensed practical nurse (LPN)-B then stood over R12 in front of the bathroom door and began to yell at R12 while pointing at an activity assistant (AA)-B "He can't use the machine, we need two people to use the machine and we don't have anyone else." R12 then attempted to get past LPN-B and into the bathroom. R12 began to grab out toward LPN-B. LPN-B yelled at the resident "Don't you hit me, my dear." R12 continued to try to get past LPN-B into the bathroom stating, "I have to pee, that's where I go, I have to pee." LPN-B stated "I know [R12] but I don't have any help." LPN-B directed AA-B to "get help" and AA-B left the memory care unit. R12 then grabbed LPN-B's arm and LPN-B began to yell in R12's face "ouch, ouch, ouch, ouch, ouch" while trying to remove her arm from R12's grasp. Another NA entered the unit, went directly toward R12 and LPN-B and stated calmly to R12 she was "here to help [R12] to the bathroom." R12 let go of LPN-B's arm, appeared calm and was assisted to the bathroom. LPN-B was not observed to write R12 a note of when she would be assisted to the bathroom.

LPN-B was interviewed on 5/31/16, at 5:03 p.m. regarding the incident that occurred with R12. LPN-B stated R12 became "very agitated, very quickly and was grabbing me by the wrists and hands." LPN-B stated "this happens a lot with her."

Interview with the nurse manager RN-C on 6/2/16, at 12:00 p.m. revealed R12 had a history of behaviors and staff was directed to keep R12 on a toileting plan and hand notes to her regarding what time she would be assisted to the bathroom. RN-C stated that she would expect

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F 241	Continued From page 7 staff to walk away from R12 and reapproach later if R12 was being physically aggressive towards staff. RN-C indicated staff have been trained to work with residents who have behaviors and would not expect staff to treat R12 in a demeaning manor. The director of nursing (DON) was interviewed on 6/2/16, at 1:00 p.m. and stated all staff receive training on how to care for residents with dementia and behaviors. The DON further stated she expected staff to follow the care plan for all residents and act in a professional and therapeutic way even with residents who exhibit behaviors. A facility policy titled Good Samaritan Society Resident Dignity, dated February 2013, was reviewed. The policy indicated a purpose of maintaining the dignity of all residents and to assist with respecting and abiding by resident rights. .	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 246	F-246	7/11/16

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F 246	Continued From page 8 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: 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 intact cognition, and did not exhibit any behaviors. R49 required extensive assistance of two staff for bed mobility, transfers, and toilet use. R49 was able demonstrate use of her call light upon request. The Care Plan dated 3/17/16, identified R49 was dependent on staff for cares and was able to call for assistance using the call light. The undated Visual/Bedside Kardex report indicated "Resident is able to call for assistance when in pain." On 6/1/16, at 9:03 a.m. resident R49 was observed and interviewed and the call light was not within reach. R49 was sitting in her wheelchair with a tray table attached (for crafts), the wheel chair was sitting at a 45 degree angle to the recliner, and the call light was on the floor on the far side of the recliner. R49 asked to have the call light handed to her, she was then able to use it appropriately and it did function. On 6/3/16, at 11:15 a.m. the Director of Nursing (DON) verified R49 can use her call light, and that it should have been within reach. -At 12:22 p.m. the maintenance man stated, "Even I was taught that if you take a patient into a room, you give them the call light, or if you stop in and they don't have the call light, you give it to them."	F 246	Corrected Date: July 11, 2016 It is the current policy and procedure of GSS-Windom to assure each resident has their call light within reach, while in their room. The call light was secured within reach for R49 at the time of the survey observation. All residents are at risk for this deficient practice and will be audited via the schedule below. All employees will be re-educated by the Director of Nursing regarding resident call light placement and the importance of securing the call light within reach of the resident by July 11, 2016. A random audit will occur by the Safety Committee of call light placement 5x/week for 2 weeks, then 3x/week for 4 weeks, and then monthly x2. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 246	Continued From page 9 The facility policy dated September 2012, directed: "Purpose: To ensure resident always has a method of calling for assistance." "Procedure: 3. When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it."	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide consistent activity programming for 2 of 4 residents (R21, R50) who were dependent on staff to attend activity programs. Findings include: 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	F 248	F-248 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. The care plans and activity assessments were reviewed and updated as necessary for R21 and R50 by July 1, 2016. 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	7/11/16

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F 248	Continued From page 10 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. An Activity Interest Data Collection Tool dated 7/10/15, indicated R21's interests included gardening, singing, movies, bingo, puzzles, religious activities and word games. A facility document titled Bedside Kardex Report, undated, directed staff to invite R21 to food related activities and offer food, beverage of choice, and encourage intake. R21's care plan dated 9/1/15, indicated she was dependent on staff for activities, cognitive stimulation, and social interaction. The care plan indicated R21's preferred activities included coffee club, hymn sing, outdoor rides, pet visits and listening to the radio. R21's quarterly Minimum Data Set (MDS) dated 3/25/16, indicated she was severely cognitively	F 248	July 1, 2016. The Activity Director was educated by the Administrator on June 23, 2016 regarding the need to put all activities for all residents on the calendar. The July activity calendar will reflect this change. The activity staff will be re-educated by the Activity Director on June 28 and 29, 2016, and the nursing staff will be re-educated by the Activity Director and Director of Nursing on June 28, 29, and 30, 2016, regarding inviting and assisting residents of all cognitive levels to various activities, the activity interests and assessments of individual residents, interacting with residents with cognitive deficits, and the various types of program options for different groups of residents. An audit will occur of the activity calendar by the Administrator or designee for 4 months to assure there are activities for residents with cognitive impairment. An audit will occur of the activity programming by the Activity Director or designee to assure residents with cognitive impairment are invited and assisted to activities for 5x/week for 4 weeks, then 3x/week for 4 weeks, and then monthly x2. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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impaired and was totally dependent on staff to move from one location to another within the facility and on the unit.

During an interview on 6/3/16, at 9:08 a.m., nursing assistant (NA)-M stated the activities on the unit depended on the person. She stated R21 was new to the unit and she was unsure what her interests were.

During an interview on 6/3/16, at 9:58 a.m., AA-A stated she worked both evenings and days. She stated in the afternoon the residents watched movies and would go to the activity room for crafts. AA-A stated R21 did not participate in the activities and would just observe. AA-A further stated she had not received any training regarding activities for cognitively impaired residents.

R50 was sitting in her wheel chair at the breakfast 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 escorted 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 not attend the outside activity even though she had

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GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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F 248	Continued From page 12 asked a staff member about going outside. R50's care plan dated 6/4/15, indicated she required staff to anticipate her needs and directed staff to invite and assist her to bingo, bible study, devotions, pet visits and special musical programs. An Activity Interest Data Collection Tool, dated 4/19/16, indicated R50 enjoyed listening to music, singing, discussion, exercise, religious activities, and family visits. A facility document titled Bedside Kardex Report, undated, directed staff to invite R50 to bingo, bible study, and musical entertainment. An annual MDS dated 4/22/16, indicated she was severely cognitively impaired and required total assistance from staff to move from one location to another. During an interview on 6/3/16, at 9:10 a.m., NA-M stated R50 did not really like to watch television but would go to bingo once in a while. During an interview on 6/3/16, at 9:22 a.m., the director of activities (DA) stated the residents who reside on the secured unit of the facility have a separate calendar for activities, but the residents who reside on the Center unit which included R21 and R50, share a calendar with the rest of the facility even though they have severe cognitive impairment. The DA stated all activities can be adapted to any ability and stated they have separate activities for those residents but they are not put on the calendar. The AD stated R21 liked music and small group programming with sensory objects. She stated R50 was a teacher and enjoyed spelling bees and small group	F 248		

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F 248	Continued From page 13 programming. The AD stated the small group programs were done whenever it could be fit in. She stated the activities department was fully staffed only four days per week and on those days they can do more. During an interview on 6/3/16, at 9:34 a.m., registered nurse (RN)-B stated there was a variety of activities for cognitively impaired residents on the unit. She stated, "I think activities checks with them." She stated she was unsure of what R50 liked to do and stated she thought R21 went to bible study. While the center station of the facility had multiple cognitively impaired residents, and while the AD indicated small group activities were done with these residents, there was no evidence of activities designed for cognitively impaired residents who were dependent on staff for activity attendance and resided outside the secured memory care unit. Further, while activities had occurred during the course of the survey, R21 and R50, who were dependent on staff to attend activities were not invited to participate in the activities. A policy titled Good Samaritan Society, Guidelines In Programming For The Special Care Unit Resident, and dated August 2012 was reviewed. The policy directed staff to develop a daily or monthly calendar of events according to the current abilities of the residents. The policy further directed staff to provide activities each morning, afternoon and evening.	F 248		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		7/11/16

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F 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care to deescalate behavior for 1 of 1 resident (R12) who was to receive written communication for bathroom use according to the plan of care. In addition, the facility failed to provide onsistent activity programming for 3 of 4 residents (R21, R50, R46) who were dependent on staff to attend activity programs. Findings include: R12's care plan dated 4/22/16, indicated R12 "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." Review of R12's Significant Change MDS Assessment dated 4/29/16, indicated R12 had	F 282	F-282 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, as well as to respect all resident rights, including those regarding dignity and preferences. The care plans and activity assessments will be reviewed and updated as necessary for R21, R46, and R50 by July 1, 2016. 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 July 1, 2016. The Activity Director was educated by the Administrator on June 23, 2016 regarding the need to put all activities for all residents on the calendar. The July activity calendar will reflect this change. The Activity Director was educated on June 3, 2016, by a Good Samaritan Society National Campus consultant regarding how to run various reports to	

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F 282	Continued From page 15 severe cognitive impairment and was totally 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 door. Licensed practical nurse (LPN)-B then stood over R12 in front of the bathroom door and began to yell at R12 while pointing at an activity assistant (AA)-B "He can't use the machine, we need two people to use the machine and we don't have anyone else." R12 then attempted to get past LPN-B and into the bathroom. R12 began to grab out toward LPN-B. LPN-B yelled at the resident "Don't you hit me, my dear." R12 continued to try to get past LPN-B into the bathroom stating, "I have to pee, that's where I go, I have to pee." LPN-B stated "I know [R12] but I don't have any help." LPN-B directed AA-B to "get help" and AA-B left the memory care unit. R12 then grabbed LPN-B's arm and LPN-B began to yell in R12's face "ouch, ouch, ouch, ouch, ouch" while trying to remove her arm from R12's grasp. Another NA entered the unit, went directly toward R12 and LPN-B and stated calmly to R12 she was "here to help [R12] to the bathroom." R12 let go of LPN-B's arm, appeared calm and was assisted to the bathroom. LPN-B was not observed to write R12 a note of when she would be assisted to the bathroom. LPN-B was interviewed on 5/31/16, at 5:03 p.m. regarding the incident that occurred with R12. LPN-B stated R12 became "very agitated, very quickly and was grabbing me by the wrists and hands." LPN-B stated "this happens a lot with her."	F 282	obtain needed information. The activity staff will be re-educated by the Activity Director on June 28 and 29, 2016, and the nursing staff will be re-educated by the Activity Director and Director of Nursing on June 28, 29, and 30, 2016, regarding inviting and assisting residents of all cognitive levels to various activities, the activity interests and assessments of individual residents, interacting with residents with cognitive deficits, and the various types of program options for different groups of residents. An audit will occur of the activity calendar by the Administrator or designee for 4 months to assure there are activities for residents with cognitive impairment. An audit will occur of the activity programming by the Activity Director or designee to assure residents with cognitive impairment are invited and assisted to activities for 5x/week for 4 weeks, then 3x/week for 4 weeks, and then monthly x2. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated. R20□s care plan was reviewed and found to be appropriate by the case manager. Other residents with dementia are at risk for similar deficient practices by this nurse. LPN-B was re-educated regarding dementia, therapeutic ways to interact with residents with dementia, and following care plans on June 6 and 17, 2016, by the Director of Nursing using	

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F 282	Continued From page 16 Interview with the nurse manager RN-C on 6/2/16, at 12:00 p.m. revealed R12 had a history of behaviors and staff was directed to keep R12 on a toileting plan and hand notes to her regarding what time she would be assisted to the bathroom. RN-C stated that she would expect staff to walk away from R12 and reapproach later if R12 was being physically aggressive towards staff. RN-C indicated staff have been trained to work with residents who have behaviors and would not expect staff to treat R12 in a demeaning manor. The director of nursing (DON) was interviewed on 6/2/16, at 1:00 p.m. and stated all staff receive training on how to care for residents with dementia and behaviors. The DON further stated she expected staff to follow the care plan for all residents and act in a professional and therapeutic way even with residents who exhibit behaviors. A facility policy titled Good Samaritan Society Resident Dignity, dated February 2013, was reviewed. The policy indicated a purpose of maintaining the dignity of all residents and to assist with respecting and abiding by resident rights. R21's care plan dated 9/1/15, indicated she was dependent on staff for activities, cognitive stimulation, and social interaction. The care plan indicated R21's preferred activities included coffee club, hymn sing, outdoor rides, pet visits and listening to the radio. R21's quarterly Minimum Data Set (MDS) dated 3/25/16, indicated she was severely cognitively impaired and was totally dependent on staff to move from	F 282	written and on-line materials. All nursing staff will be re-educated by the Director of Nursing on June 28, 29, and 30, 2016 regarding following the care plan and therapeutic interventions for persons with dementia. An observation audit will be conducted by the Director of Nursing or designee to ensure employees are initiating the therapeutic interventions listed on the care plan of residents with dementia, 5x/week for 2 weeks, then 3x/week for 4 weeks, and then monthly x2. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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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 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 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.

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. Her care plan dated 5/14/16, indicated impaired 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.

R46 was in a reclining chair in the common area

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of the unit. She was sleeping in front of the television during an observation on 6/1/16, at 9:24 a.m. During an observation on 6/2/16, at 9:19 a.m., R46 was in a reclining wheel chair in the common area of the unit. She was sleeping in front of the television. At 11:36 a.m. in the main dining room, the facility chaplain was singing hymns and reciting a prayer before the noon meal. R46 was not in attendance, she was sitting in the small dining room on the unit she resides on. At 12:09 p.m., R46 was sleeping in her room in her reclining wheel chair, at 1:47 p.m., staff put her in bed. R46 did not attend the outside activity at 2:00 p.m. During an observation on 6/3/16, at 9:57 a.m., R46 was sitting in her wheelchair in the front entrance of the facility sitting in front of the bird aviary. She was asleep.

R50's care plan dated 6/4/15, indicated she required staff to anticipate her needs and directed staff to invite and assist her to bingo, bible study, devotions, pet visits and special musical programs. An annual MDS dated 4/22/16, indicated she was severely cognitively impaired and required total assistance from staff to move from one location to another.

R50 was sitting in her wheel chair at the breakfast 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.

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At 11:29 a.m., R50 was escorted 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 not attend the outside activity.

During an interview on 6/3/16, at 9:08 a.m., nursing assistant (NA)-M stated the activities on the unit depended on the person. She stated R21 was new to the unit and she was unsure what her interests were. NA-M stated R50 did not really like to watch television but would go to bingo once in a while.

During an interview on 6/3/16, at 9:58 a.m., AA-A stated she worked both evenings and days. She stated in the morning she would bring the residents to sit in front of the nird aviary but stated they often slept. She stated in the afternoon the residents watched movies and would go to the activity room for crafts. AA-A stated R21 did not participate in the activities and would just observe. She stated R46 also went to the activity room for crafts but was not able to participate, she just observed.

During an interview on 6/3/16, at 9:22 a.m., the director of activities (DA) stated the residents who resided on the Center unit which included R21, R46 and R50 share a calendar with the rest of the facility even though they have severe cognitive impairment. The DA stated the facility had separate activities for those residents but they are not put on the calendar. The AD stated the small group programs are done whenever it can be fit in. She stated the activities department was fully staffed only four days per week and on those days they can do more. The AD stated each

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F 282	Continued From page 20 resident was assessed upon admission, annually and if there was a significant change, as well as when cognition or ability changes. However, she stated she was unable to determine which activities each resident was participating in, but could view whether it was an individual self-directed activity or a group activity. A policy titled Good Samaritan Society, Care Plan, and dated June 2012 was reviewed. The policy directed staff to develop a comprehensive care plan that emphasizes the care and development of the whole person, ensuring that the resident receives appropriate care and services.	F 282		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.	F 373		7/11/16

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F 373	Continued From page 21 Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 373	F-373	

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F 373	Continued From page 22 review, the facility failed to ensure 1 of 1 residents (R110) reviewed for assistance with eating, was assessed to be safely fed by a non-nursing staff. Findings include: During an entrance conference with the administrator on 5/21/16, at 12:05 p.m. the administrator indicated the facility did not utilize paid feeding assistants and all activity staff were certified nursing assistants. R110 admitted to the facility on 5/17/16, with a diagnosis of dementia and resided in the memory care unit. R110's admission Minimum Data Set (MDS) assessment dated 5/17/16, identified R110's cognition was severely impaired and R110 required staff assistance with eating. R110's care plan dated 5/17/16, further identified R110 required staff assistance with eating and no feeding assistants were to assist R110 with eating. R110's undated nursing Kardex indicated R110 required assistance with eating and identified no paid feeding assistants were to assist R110. On 5/31/16, at 5:34 p.m. an activity assistant (AA)-B was observed assisting with the evening meal. AA-B was observed passing food trays to residents seated at tables in the memory care unit. -At 5:47 p.m. AA-B was observed to sit at a table between R89 and R110. AA-B was observed to place pureed meat on spoon, holding to R110's mouth and said " Please open your mouth. " R110 kept mouth closed and AA-B kept the spoon next to R110's mouth. R110 started saying "is that " and AA-B attempted to place the spoon in R110's mouth while it was open. R110 then	F 373	Corrected Date: July 11, 2016 It is the current policy and procedure of GSS-Windom to follow all feeding assistant guidelines. R110 care plan was reviewed and found to be appropriate. Residents at risk of this deficient practice are those who have complicated feeding problems. AA-B was re-educated regarding the feeding assistant policy and who they are able to assist and who they cannot on June 24, 2016 by the Director of Nursing. All nurses will be re-educated by the Director of Nursing on June 28, 29, and 30, 2016, regarding the feeding assistant policy and their responsibility to direct who the feeding assistant will feed. An observation audit will occur of the feeding assistant and who he is feeding by the Director of Nursing or designee each time the assistant is performing this duty x4 weeks. The facility employs no other feeding assistants. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 373	Continued From page 23	F 373		

attempted to push the AA-B's hand away and AA-B continued to hold the spoon to R110'S teeth saying "open your mouth please, open your mouth please. " When R110 did not open her mouth, AA-B set the spoon down and asked R110 if she would like a drink of milk. AA-B provided the cup of milk to R110 and she drank from it.
-At 5:55 p.m. AA-B put a spoon full of R110 ' S potatoes in her milk and stirred them with a knife. AA-B then gave R110 the milk to drink. R110 drank the milk.
-At 5:56 p.m. AA-B added an additional spoonful of mashed potatoes to the milk, stirred the milk with a knife and handed the milk to R110 to drink.
-At 5:57 p.m. R110 was provided an additional drink of milk. AA-B continued to offer the milk mixed with mashed potatoes during the evening meal.
-At 6:02 p.m. AA-B added another spoonful of mashed potatoes to R110's milk and continued to offer her drinks of milk until 6:07 p.m. when the resident walked away from the table.
-R110 was not offered additional food or choices during the evening meal. R110 was offered one bite of pureed meat and her milk which was mixed with mashed potatoes during the evening meal.

AA-B was interviewed on 5/31/16, at 6:13 p.m. and stated R110's dentures do not fit well so potatoes are put in her milk for better intake.

On 6/3/16 at 12:40 p.m. during a review of employee files AA-B was identified as a paid feeding assistant and did not have nursing assistant training. The employee file included completed paid feeding assistant training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	06/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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F 373	Continued From page 24 On 6/3/16, at 12:52 p.m. the director of nursing (DON) confirmed AA-B was a paid feeding assistant and should not have been assisting R110. The DON confirmed R110 was identified on a list of residents that paid feeding assistants were not to assist with meals. The DON further indicated AA-B and the nurse who is supervising the meal, should be aware of who paid feeding assistants are and which residents they can assist. A paid feeding assistant policy was not provided by the facility.	F 373		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		7/11/16

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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: Based on observation, interview and document review, the facility failed to ensure medications were securely stored for 1 of 1 resident (R20) reviewed. In addition, the facility failed to ensure 1 of 3 medication carts (cart on 200 wing) was appropriately secured. Findings include: On 5/31/16 between 4:58 p.m. through 5:04 p.m. an observation was made on the memory care unit of medications being stored on the medication cart. A clear, non-labeled, medication cup with crushed medications in it was observed sitting on the medication cart as well as two large bottles of liquid Gabapentin 250 mg/ml (milligrams/milliliter) with R20's name on the labels. Licensed practical nurse (LPN)-B was interviewed at 5:04 p.m. LPN-B confirmed she had left the clear medication cup on top of the cart and stated there were crushed medications in the cup including Levothyroxine (thyroid medication) and Digoxin (regulates the heart). In addition, LPN-B	F 431	F-431 Corrected Date: July 11, 2016 It is the current policy and procedure of GSS-Windom to dispense and store drugs according to current medication administration guidelines. The medication for R20 was corrected at the time of the survey observation. The nurse in charge of the 200-wing cart corrected her mistake at the time of the survey observation, when she was corrected by the surveyor. As all residents are at risk of this deficient practice, all nurses and trained medication aides will be re-educated by the Director of Nursing on proper medication administration procedures on June 28, 29, and 30, 2016. LPN-B and RN-C received individualized education on June 6, 2016 and June 2, 2016, respectively, by the Director of Nursing.	

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F 431	Continued From page 26 confirmed R20's Gabapentin bottles had been left on top of the cart. At 5:11 p.m. on 5/31/16, the two bottles of Gabapentin continued to be observed on the left side of the medication cart. LPN-B stated she was "going on break" and locked the medication cart, LPN-B was observed to move the two bottles of Gabapentin to the right side of the top of the cart and walked away. During continuous observation of the medication cart from 4:58 p.m. until 6:10 p.m. on 5/31/16, the two bottles of Gabapentin remained on top of the medication cart. At 6:10 p.m., LPN-B returned and confirmed she had left the Gabapentin on the cart. The director of nursing (DON) was interviewed on 6/2/16, at 11:50 a.m. The DON verified R20's Gabapentin should not have been left on top of the medication cart. The DON said she would expect staff to pour out the dosage of medication prescribed, and to put the bottle back in the refrigerator which was secured. On 6/1/16, at 9:34 a.m. registered nurse (RN)-C (a nurse from the 200 unit) was observed to unlock a medication cart, and place her keys on top while looking for eye drops for R15. RN-C then shut the medication drawer she was looking in, and proceeded around the corner and down the hallway to give R15 eye drops. RN-C did not lock the cart, nor pick up her cart keys prior to walking away from the cart. RN-C returned to the unlocked medication cart at 9:39 a.m. At that time, the surveyor asked RN-C about walking away from the cart which was unlocked and had keys on top. RN-C only acknowledged the question with "uh. " During review of the	F 431	An observation audit will occur of drug administration and storage by the Director of Nursing or designee, 3x/week for 2 weeks, then weekly x 4 weeks, and then monthly x2. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 431	Continued From page 27 medication cart, it was noted to contain insulin pens, and numerous oral medications for residents. During interview with the DON at 3:30 p.m., the DON verified she'd been made aware RN-C had left the medication cart unlocked with the keys on top. The DON verified the medication cart should be kept locked and the keys should be kept with the person responsible for passing medications. The facility policy entitled Acquisition, Receiving, Dispensing and Storage of Medications dated 12/15, indicated: "medication will be stored in a locked medication cart, drawer or cupboard. Only the person passing the medications and the director of nursing services will be permitted to have access to the keys to the medications storage areas."	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assure a room call light was functioning for 1 of 35 residents (R107) residing in the facility. Findings include: R107's was admitted to the facility on 5/19/16.	F 463	F-463 Corrected Date: July 11, 2016 It is the current policy and procedure of GSS-Windom to provide functioning call lights and to check them for operability quarterly.	7/11/16

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F 463	Continued From page 28 The admission Minimum Data Set (MDS) dated 5/25/16, identified R107 had severe cognitive impairment, however was able to be interviewed for Stage I data. The MDS indicated R107 required two person assist for bed mobility and one person assist for all other activities of daily living except eating. The care plan dated 5/20/16, indicated R107 required staff assist to manage bladder/bowel incontinence and was at risk for falls. The care plan indicated staff needed to remind the resident not to bend over to pick up dropped items and encourage the use of a grabber or ask for assistance. On 5/31/16, at 4:24 p.m. the call light in R107's room was observed to be pinned to the sheets on her bed. R107 was sitting up on the edge of the bed, was able to identify and press the call light, which resulted in it being nonfunctional. Nursing assistant (NA)-A and registered nurse (RN)-A verified the call light was not functional, with RN-A stating "I will contact maintenance." 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. During an interview on 6/3/16, at 12:03 p.m. HS stated she conducts quarterly audits on call light functions for each resident and typically a NA or the resident would tell maintenance if it wasn't functioning. The call was logged with maintenance and the director of maintenance would have it fixed. HS stated EA would have the policy.	F 463	The call light for 107 was fixed at the time of the survey observation. All resident call lights were checked by maintenance staff by June 24, 2016, to assure operability and were repaired if needed. The facility has a successful system for identifying and fixing equipment via our Maintenance Hotline, as well as quarterly checks of each room, including the call lights. EA was re-educated about these procedures on June 22, 2016. All maintenance staff will be re-educated on June 29, 2016. Audits of all call lights will be done bi-weekly for 6 weeks, then monthly x3 by the Safety Committee. Audit results will be reviewed by the QAPI Committee for further recommendations.	

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F 463	Continued From page 29 During an interview on 6/3/16, at 12:18 p.m. EA stated "if staff or anybody tells me I replace it." EA stated that staff would call the maintenance Hotline system which started in January and we then address it, except if we consider it an emergency, "we do it immediately, like nonfunctioning call lights." EA verified the facility did not have a written policy. Review of the facility Procedure for Call Light dated September 2012, indicated the purpose was to ensure residents always had a method of calling for assistance but lacked direction on how to report nonfunctioning call lights.	F 463		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner to promote sanitation and food safety in the main kitchen. This practice had the potential to affect all 76 residents who received food from the kitchen. Findings include: During the kitchen tour on 5/31/16, at 12:20 p.m. the following sanitation concerns were observed	F 465	F-465 Corrected Date: July 11, 2016 It is the current policy and procedure of GSS-Windom to provide a clean and sanitary kitchen environment. The griddle and oven were cleaned on June 2, 2016. All other kitchen equipment is at risk for this deficient practice and will be audited	7/11/16

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F 465	Continued From page 30 and confirmed by the Director of Dietary (DD): - 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 knobs on the flat top griddle were dirty and sticky with a buildup of a brown/black substance. During a follow-up kitchen tour on 6/2/16, at 1:25 p.m. the following sanitation concerns were observed and verified by the DD: - The six burner stove with three sets of two grates had a buildup of a greasy black food debris in the corners of the grates and between each set of grates. The outside of the oven door situated below the stove burner stove had food splatter down the front of it and there was grease and food debris caked on and around the corners of the handle. All six knobs had a heavy buildup of brown/black substance on and around the knobs. - The flat top griddle front plate was covered with a sticky, brown greasy residue with food spills down the front panel of the unit. DD verified both units needed cleaning and although they have a cleaning schedule, she was not sure if the two units were scheduled for deep cleaning. During an interview on 6/3/16, at 10:55 a.m. DD stated the deep cleaning of the stove was not on the cleaning duty list "but it is now." DD verified the deep cleaning duties was the policy and in effect prior to survey. Review of the undated Sunday Cleaning Duties	F 465	and followed up on as appropriate by July 1, 2016 for cleanliness. All dietary staff will be re-educated on cleaning practices by July 11, 2016. An audit by the Dietary Director or designee will occur of kitchen equipment cleanliness, 5x/week for 2 weeks, then 3x/week for 2 weeks, and then weekly x4 weeks. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 465	Continued From page 31 policy did not include cleaning of either the flat top griddle or the six burner stove. Review of the undated Deep Cleaning Duties policy indicated the AM cook was responsible for cleaning the "grill" and the PM cook was responsible for cleaning the "cook's oven and stove top area."	F 465		

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	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/01/2016**

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K 000	INITIAL COMMENTS 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:	K 000	EPOC	

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Windom is a one-story building with partial basement, and was constructed at five different times. The original building was constructed in 1959, with building additions in 1962, 1972, 1994 and 2000. All buildings were determined to be of Type II(111) construction. The facility is fully sprinklered. The building has a fire alarm system with smoke detection in the corridors, including all spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 77 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and	K 025		6/29/16

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K 025	Continued From page 2 constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 FINDINGS INCLUDE: During Facility Inspection on June 01, 2016, between the hours of 12:30 PM and 3:00 PM, observation revealed penetrations around electrical cables above the lay in ceilings at the 100 wing smoke barrier and the 500 wing smoke barrier. This deficient practice was verfied by the Maintenance Supervisor.	K 025	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. K-25 Corrected Date: June 29, 2016 The penetrations in the walls were repaired on June 9, 2016. All other walls were checked and found to be compliant or were corrected as necessary on June 9, 2016. Education regarding staff monitoring and following up with outside contractors to assure any penetrations were fixed at the time of service will be provided to maintenance staff on June 29, 2016	

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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 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 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) FINDINGS INCLUDE: During Facility Inspection and Documentation Review on June 01, 2016,between the hours of 12:30 PM and 3:00PM, the following was discovered: 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.	K 144	K-144 Corrected Date: June 29, 2016 Re-education was provided to the nursing home maintenance supervisor regarding the policy and importance of emergency generator weekly checks on June 22, 2016. All maintenance staff will be re-educated on the weekly generator checks on June 29, 2016. The Safety Coordinator and Maintenance Director will monitor the facility for future issues through the Safety Meeting audits and the QAPI committee.	6/29/16

MDH
Minnesota
Department
of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	06/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 31, 2016 to June 3, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. An investigation of complaint number H5558011 was completed at the time of the extended survey and was found to be unsubstantiated.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care to deescalate behavior for 1 of 1 resident (R12) who was to receive written communication for bathroom use according to the plan of care. In addition, the facility failed to provide onsistent activity programming for 3 of 4 residents (R21, R50, R46) who were dependent on staff to attend activity programs. Findings include: R12's care plan dated 4/22/16, indicated R12 "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	2 565	Acknowledged	7/11/16

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2 565	Continued From page 3 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." Review of R12's Significant Change MDS Assessment dated 4/29/16, indicated R12 had severe cognitive impairment and was totally 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 door. Licensed practical nurse (LPN)-B then stood over R12 in front of the bathroom door and began to yell at R12 while pointing at an activity assistant (AA)-B "He can't use the machine, we need two people to use the machine and we don't have anyone else." R12 then attempted to get past LPN-B and into the bathroom. R12 began to grab out toward LPN-B. LPN-B yelled at the resident "Don't you hit me, my dear." R12 continued to try to get past LPN-B into the bathroom stating, "I have to pee, that's where I go, I have to pee." LPN-B stated "I know [R12] but I don't have any help." LPN-B directed AA-B to "get help" and AA-B left the memory care unit. R12 then grabbed LPN-B's arm and LPN-B began to yell in R12's face "ouch, ouch, ouch, ouch, ouch" while trying to remove her arm from R12's grasp. Another NA entered the unit, went directly toward R12 and LPN-B and stated calmly	2 565		

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2 565	Continued From page 4	2 565		

to R12 she was "here to help [R12] to the bathroom." R12 let go of LPN-B's arm, appeared calm and was assisted to the bathroom. LPN-B was not observed to write R12 a note of when she would be assisted to the bathroom.

LPN-B was interviewed on 5/31/16, at 5:03 p.m. regarding the incident that occurred with R12. LPN-B stated R12 became "very agitated, very quickly and was grabbing me by the wrists and hands." LPN-B stated "this happens a lot with her."

Interview with the nurse manager RN-C on 6/2/16, at 12:00 p.m. revealed R12 had a history of behaviors and staff was directed to keep R12 on a toileting plan and hand notes to her regarding what time she would be assisted to the bathroom. RN-C stated that she would expect staff to walk away from R12 and reapproach later if R12 was being physically aggressive towards staff. RN-C indicated staff have been trained to work with residents who have behaviors and would not expect staff to treat R12 in a demeaning manor.

The director of nursing (DON) was interviewed on 6/2/16, at 1:00 p.m. and stated all staff receive training on how to care for residents with dementia and behaviors. The DON further stated she expected staff to follow the care plan for all residents and act in a professional and therapeutic way even with residents who exhibit behaviors.

A facility policy titled Good Samaritan Society Resident Dignity, dated February 2013, was reviewed. The policy indicated a purpose of maintaining the dignity of all residents and to assist with respecting and abiding by resident

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2 565	Continued From page 5 rights. R21's care plan dated 9/1/15, indicated she was dependent on staff for activities, cognitive stimulation, and social interaction. The care plan indicated R21's preferred activities included coffee club, hymn sing, outdoor rides, pet visits and listening to the radio. R21's quarterly Minimum Data Set (MDS) dated 3/25/16, indicated she was severely cognitively impaired and was totally dependent on staff to move from 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 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 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.	2 565		

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2 565	Continued From page 6 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. Her care plan dated 5/14/16, indicated impaired 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. R46 was in a reclining chair in the common area of the unit. She was sleeping in front of the television during an observation on 6/1/16, at 9:24 a.m. During an observation on 6/2/16, at 9:19 a.m., R46 was in a reclining wheel chair in the common area of the unit. She was sleeping in front of the television. At 11:36 a.m. in the main dining room, the facility chaplain was singing hymns and reciting a prayer before the noon meal. R46 was not in attendance, she was sitting in the small dining room on the unit she resides on. At 12:09 p.m., R46 was sleeping in her room in her reclining wheel chair, at 1:47 p.m., staff put her in bed. R46 did not attend the outside activity at 2:00 p.m. During an observation on 6/3/16, at 9:57 a.m., R46 was sitting in her wheelchair in the front entrance of the facility sitting in front of the bird aviary. She was asleep. R50's care plan dated 6/4/15, indicated she required staff to anticipate her needs and directed staff to invite and assist her to bingo, bible study, devotions, pet visits and special musical programs. An annual MDS dated 4/22/16, indicated she was severely cognitively impaired and required total assistance from staff to move from one location to another. R50 was sitting in her wheel chair at the breakfast table alone during an observation on 6/2/16, at7:26 a.m. her eyes were closed and her head	2 565		

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2 565	Continued From page 7	2 565		

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 escorted 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 not attend the outside activity.

During an interview on 6/3/16, at 9:08 a.m., nursing assistant (NA)-M stated the activities on the unit depended on the person. She stated R21 was new to the unit and she was unsure what her interests were. NA-M stated R50 did not really like to watch television but would go to bingo once in a while.

During an interview on 6/3/16, at 9:58 a.m., AA-A stated she worked both evenings and days. She stated in the morning she would bring the residents to sit in front of the nird aviary but stated they often slept. She stated in the afternoon the residents watched movies and would go to the activity room for crafts. AA-A stated R21 did not participate in the activities and would just observe. She stated R46 also went to the activity room for crafts but was not able to participate, she just observed.

During an interview on 6/3/16, at 9:22 a.m., the director of activities (DA) stated the residents who resided on the Center unit which included R21, R46 and R50 share a calendar with the rest of the

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2 565	Continued From page 8 facility even though they have severe cognitive impairment. The DA stated the facility had separate activities for those residents but they are not put on the calendar. The AD stated the small group programs are done whenever it can be fit in. She stated the activities department was fully staffed only four days per week and on those days they can do more. The AD stated each resident was assessed upon admission, annually and if there was a significant change, as well as when cognition or ability changes. However, she stated she was unable to determine which activities each resident was participating in, but could view whether it was an individual self-directed activity or a group activity. A policy titled Good Samaritan Society, Care Plan, and dated June 2012 was reviewed. The policy directed staff to develop a comprehensive care plan that emphasizes the care and development of the whole person, ensuring that the resident receives appropriate care and services. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could monitor meal service to determine and establish staffing needs. The director of nursing or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in	2 830		7/11/16

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2 830	Continued From page 9 the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to 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 (R12) reviewed for dignity. Findings include: R18's care plan dated 9/28/15, indicated she had limited physical mobility and directed staff to assist with dressing, grooming, personal hygiene, and transfers using a mechanical stand lift with assistance of two staff. R18's quarterly Minimum Data Set (MDS) dated 3/11/16, indicated she was severely cognitively impaired. R21's care plan dated 9/1/15, indicated she required extensive assist for all ADL's and directed staff to assist with dressing, grooming and personal hygiene, and to transfer R21 with a mechanical stand lift if weak. R21's quarterly	2 830	Acknowledged	

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2 830	Continued From page 10 MDS dated 3/25/16 indicated she was severely cognitively impaired. 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. R24's annual MDS dated 3/4/16, indicated she was moderately cognitively impaired and a decreased ability to make herself understood or understand others. R24's care plan dated 3/17/16, indicated she had limited physical ability related to hemiplegia and directed staff to assist with dressing, grooming, personal hygiene, and transfers using a mechanical stand lift with two staff. During an observation on 6/3/16, and 6:19 a.m., R24 was dressed and seated at the table on the unit. R24 stated "they get me up too early." At 9:06 a.m., R24 was asleep in a recliner chair in her room. R34's quarterly MDS dated 4/20/16, indicated he was severely cognitively impaired. R34's care plan dated 2/20/16, indicated he required physical assist for dressing, grooming and personal hygiene, including bathing. During an observation on 6/3/16, at 6:33 a.m., R34 was ambulating down the hall with staff toward the shower room. During an interview on 6/3/16, at 9:12:10 a.m., nursing assistant (NA)-M stated she had to wake R34 up every week for his bath. R42's care plan dated 11/12/15, indicated an ADL deficit and directed staff to assist with all activities of daily living and transfer with a total body lift and	2 830		

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2 830	Continued From page 11	2 830		

assistance of two staff. R42's quarterly MDS dated 4/8/16, indicated she was severely cognitively impaired.

R43's care plan dated 4/14/16 indicated she required assistance of two staff for all ADL's and transferred using a total body lift. R43's quarterly MDS dated 4/1/16, indicated she was severely cognitively impaired.

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.

R46's care plan dated 5/14/15, indicated an ADL deficit related to hemiplegia and directed staff to assist with dressing, grooming, personal hygiene and transfer with a total body lift and assist of two staff. R46's quarterly MDS dated 4/1/16, indicated she was severely cognitively impaired.

R50's care plan dated 4/7/14 indicated an ADL deficit related to weakness and directed staff to assist with dressing, grooming, hygiene and transfer using a total body lift and assist of two staff. R50's Annual MDS dated 4/22/16, indicated she was severely cognitively impaired.

During an observation on 6/3/16, at 6:57 a.m., R50 was up in her wheel chair and dressed. During an observation on 6/3/16, at 7:40 a.m., R50 was sitting in her wheel chair, sleeping in front of the television.

During an interview on 6/3/16, at 7:00 a.m., NA-O stated she had to wake R50 up and get her dressed because she ate breakfast at 8:00 a.m.

R56's care plan dated 3/20/14 indicated an ADL self-care deficit and directed staff to assist with all

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2 830	Continued From page 12 activities of daily living. R56's quarterly MDS dated 4/1/16, indicated moderate cognitive impairment. R65's care plan dated 2/29/16, indicated an ADL self-care deficit and directed staff to assist her with dressing, grooming and transfers. R65's quarterly MDS indicated she was severely cognitively impaired. During an observation on 5/31/16, at 5:51 p.m., a document titled NOC (overnight) gets up was posted at the center nurse's station. The document indicated the following: "R21- 6am, R56 620am, R20- 640am and R34 7am. Two night aides get up two additional residents." A review of a facility document labeled, Center, dated 6/3/16, listed ten residents with check marks next to their names and six additional names. A review of a facility document titled 11-7, List For Getting Up In AM, and dated 5/23/16, listed six names. During an interview on 6/3/16, at 6:13 a.m., NA-B stated she gets residents up for the day based on if the call light was going off and who gets a bath. She stated, "I don't like to disturb anyone, so I will get residents washed, dressed, and leave them in bed." NA-B further stated the residents ate at 7:30 a.m., call lights are a priority and then two person transfers. During an interview on 6/3/16, at 6:45 a.m., NA-C stated she worked the overnight shift. She stated she had a list of six residents that she had to get up in the morning. NA-C stated, "I have to wake them up to get them dressed and washed and in their wheel chairs starting at 5:00 a.m. "	2 830		

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2 830	Continued From page 13 During an interview on 6/3/16, at 7:05 a.m., NA-N stated she worked the night shift. She stated she had a list of residents she had to get up in the morning. She stated if there are two staff on they get up eight people starting around 5:00 a.m. She stated they have to be ready before she leaves for the day. NA-N further stated, "We wake people up to get them dressed." During an interview on 6/3/16, at 7:09 a.m., registered nurse (RN)-B stated the number of people the night shift gets up varies depending on how many staff are on. She stated staff should be letting residents sleep unless they are a fall risk. RN-B stated she was not aware staff were waking residents up to get them ready for the day. During an interview on 6/3/16, at 7:17 a.m., RN-D stated the list of who gets up early was based on who was awake. She stated she tried to give the night shift staff residents who require assist of one with dressing and transfers. RN-D stated she arrived to work at 5:30 a.m., but she was unaware staff were waking up residents to get them ready for the day and stated, "It is not a practice we encourage." During an interview on 6/3/16, at 7:46 a.m., the director of nursing (DON) stated the night shift has a list of residents at each station who get up early. She stated the nurse manager was responsible for who was on each list and stated between the nurse managers and the overnight charge nurse they set a list which seems realistic. She stated if a resident was cognitively impaired staff may get them up and dressed and put them back into bed. The DON stated the overnight nurse should be monitoring staff to see if they are waking residents up.	2 830		

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2 830	Continued From page 14 During an interview on 6/3/16 at 9:12 a.m., NA-M stated she typically woke up several residents every day. She stated she had to wake them up so they can get to breakfast. She stated she had not been told she should let residents sleep until they were ready to get up. R12's face sheet identified an admission date of 3/30/12, with diagnoses that included dementia, depression, anxiety and delusional disorders. R12's care plan dated 4/22/16 indicated R12 "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." Review of R12's Significant Change MDS Assessment dated 4/29/16, indicated R12 had severe cognitive impairment and was totally 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 door. Licensed practical nurse (LPN)-B then	2 830		

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2 830	Continued From page 15 stood over R12 in front of the bathroom door and began to yell at R12 while pointing at an activity assistant (AA)-B "He can't use the machine, we need two people to use the machine and we don't have anyone else." R12 then attempted to get past LPN-B and into the bathroom. R12 began to grab out toward LPN-B. LPN-B yelled at the resident "Don't you hit me, my dear." R12 continued to try to get past LPN-B into the bathroom stating, "I have to pee, that's where I go, I have to pee." LPN-B stated "I know [R12] but I don't have any help." LPN-B directed AA-B to "get help" and AA-B left the memory care unit. R12 then grabbed LPN-B's arm and LPN-B began to yell in R212s face "ouch, ouch, ouch, ouch, ouch" while trying to remove her arm from R12's grasp. Another NA entered the unit, went directly toward R12 and LPN-B and stated calmly to R12 she was "here to help [R12] to the bathroom." R12 let go of LPN-B's arm, appeared calm and was assisted to the bathroom. LPN-B was not observed to write R12 a note of when she would be assisted to the bathroom. LPN-B was interviewed on 5/31/16, at 5:03 p.m. regarding the incident that occurred with R12. LPN-B stated R20 became "very agitated, very quickly and was grabbing me by the wrists and hands." LPN-B stated "this happens a lot with her." Interview with the nurse manager RN-C on 6/2/16, at 12:00 p.m. revealed R12 had a history of behaviors and staff was directed to keep R12 on a toileting plan and hand notes to her regarding what time she would be assisted to the bathroom. RN-C stated that she would expect staff to walk away from R12 and reapproach later if R12 was being physically aggressive towards staff. RN-C indicated staff have been trained to	2 830		

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2 830	Continued From page 16 work with residents who have behaviors and would not expect staff to treat R12 in a demeaning manor. The director of nursing (DON) was interviewed on 6/2/16, at 1:00 p.m. and stated all staff receive training on how to care for residents with dementia and behaviors. The DON further stated she expected staff to follow the care plan for all residents and act in a professional and therapeutic way even with residents who exhibit behaviors. A facility policy titled Good Samaritan Society Resident Dignity, dated February 2013, was reviewed. The policy indicated a purpose of maintaining the dignity of all residents and to assist with respecting and abiding by resident right. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring that residents are treated in a dignified manner. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care in a dignified manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests,	21435		7/11/16

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21435	Continued From page 17 strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide consistent activity programming for 3 of 4 residents (R21, R46, R50) reviewed for activities. Findings include: 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 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	21435	Acknowledged	

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21435	Continued From page 18 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. An Activity Interest Data Collection Tool dated 7/10/15, indicated R21's interests included gardening, singing, movies, bingo, puzzles, religious activities and word games. A facility document titled Bedside Kardex Report, undated, directed staff to invite R21 to food related activities and offer food, beverage of choice, and encourage intake. R21's care plan dated 9/1/15, indicated she was dependent on staff for activities, cognitive stimulation, and social interaction. The care plan indicated R21's preferred activities included coffee club, hymn sing, outdoor rides, pet visits and listening to the radio. R21's quarterly Minimum Data Set (MDS) dated 3/25/16, indicated she was severely cognitively impaired and was totally dependent on staff to move from one location to another within the facility and on the unit. During an interview on 6/3/16, at 9:08 a.m., nursing assistant (NA)-M stated the activities on the unit depended on the person. She stated R21 was new to the unit and she was unsure what her interests were. During an interview on 6/3/16, at 9:58 a.m., AA-A stated she worked both evenings and days. She	21435		

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stated in the afternoon the residents watched movies and would go to the activity room for crafts. AA-A stated R21 did not participate in the activities and would just observe. AA-A further stated she had not received any training regarding activities for cognitively impaired residents.

R46 was in a reclining chair in the common area of the unit. She was sleeping in front of the television during an observation on 6/1/16, at 9:24 a.m.

During an observation on 6/2/16, at 9:19 a.m., R46 was in a reclining wheel chair in the common area of the unit. She was sleeping in front of the television. At 11:36 a.m. in the main dining room, the facility chaplain was singing hymns and reciting a prayer before the noon meal. R46 was not in attendance, she was sitting in the small dining room on the unit she resides on. At 12:09 p.m., R46 was sleeping in her room in her reclining wheel chair, at 1:47 p.m., staff put her in bed. R46 did not attend the outside activity at 2:00 p.m.

During an observation on 6/3/16, at 9:57 a.m., R46 was sitting in her wheelchair in the front entrance of the facility sitting in front of the bird aviary. She was asleep.

An Activity Interest Data Collection Tool, dated 1/30/13, indicated R46's interests included bingo, cards, traveling, news, quilting and sewing, worship, gardening and animals.

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. Her care plan dated 5/14/16, indicated impaired

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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 breakfast 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 escorted 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 not attend the outside activity.

R50's care plan dated 6/4/15, indicated she required staff to anticipate her needs and directed staff to invite and assist her to bingo, bible study, devotions, pet visits and special musical programs.

An Activity Interest Data Collection Tool, dated

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21435	Continued From page 21 4/19/16, indicated R50 enjoyed listening to music, singing, discussion, exercise, religious activities, and family visits. A facility document titled Bedside Kardex Report, undated, directed staff to invite R50 to bingo, bible study, and musical entertainment. An annual MDS dated 4/22/16, indicated she was severely cognitively impaired and required total assistance from staff to move from one location to another. During an interview on 6/3/16, at 9:10 a.m., NA-M stated R50 did not really like to watch television but would go to bingo once in a while. During an interview on 6/3/16, at 9:22 a.m., the director of activities (DA) stated the residents who reside on the secured unit of the facility have a separate calendar for activities, but the residents who reside on the Center unit which included R21, R46 and R50 share a calendar with the rest of the facility even though they have severe cognitive impairment. The DA stated all activities can be adapted to any ability and stated they have separate activities for those residents but they are not put on the calendar. The AD stated R21 liked music and small group programming with sensory objects. She stated R50 was a teacher and enjoyed spelling bees and small group programming and R46 enjoyed small group programming. The AD stated the small group programs are done whenever it can be fit in. She stated the activities department was fully staffed only four days per week and on those days they can do more. During an interview on 6/3/16, at 9:34 a.m., registered nurse (RN)-B stated there was a variety of activities for cognitively impaired	21435		

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21435	Continued From page 22 residents on the unit. She stated, "I think activities checks with them." She stated she was unsure of what R50 liked to do, stated she thought R21 went to bible study and stated R46 likes to spend time in her room. While the center station of the facility had multiple cognitively impaired residents, and while the AD indicated small group activities were done with these residents, there was no evidence of activities designed for cognitively impaired residents who were dependent on staff for activity attendance and resided outside the secured memory care unit. A policy titled Good Samaritan Society, Guidelines In Programming For The Special Care Unit Resident, and dated August 2012 was reviewed. The policy directed staff to develop a daily or monthly calendar of events according to the current abilities of the residents. The policy further directed staff to provide activities each morning, afternoon and evening. SUGGESTED METHOD FOR CORRECTION: The activity director or designee could develop systems of ensuring activity programming for cognitively impaired residents. The Activity Director could educate all appropriate staff and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21435		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home	21610		7/11/16

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21610	Continued From page 23 must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were securely stored for 1 of 1 resident (R20) reviewed. In addition, the facility failed to ensure 1 of 3 medication carts (cart on 200 wing) was appropriately secured. Findings include: On 5/31/16 between 4:58 p.m. through 5:04 p.m. an observation was made on the memory care unit of medications being stored on the medication cart. A clear, non-labeled, medication cup with crushed medications in it was observed sitting on the medication cart as well as two large bottles of liquid Gabapentin 250 mg/ml (milligrams/milliliter) with R20's name on the labels. Licensed practical nurse (LPN)-B was interviewed at 5:04 p.m. LPN-B confirmed she had left the clear medication cup on top of the cart and stated there were crushed medications in the cup including Levothyroxine (thyroid medication) and Digoxin (regulates the heart). In addition, LPN-B confirmed R20's Gabapentin bottles had been left on top of the cart. At 5:11 p.m. on 5/31/16, the two bottles of Gabapentin continued to be observed on the left side of the medication cart. LPN-B stated she was "going on break" and locked the medication cart, LPN-B was observed to move the two	21610	Acknowledged	

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21610	Continued From page 24 bottles of Gabapentin to the right side of the top of the cart and walked away. During continuous observation of the medication cart from 4:58 p.m. until 6:10 p.m. on 5/31/16, the two bottles of Gabapentin remained on top of the medication cart. At 6:10 p.m., LPN-B returned and confirmed she had left the Gabapentin on the cart. The director of nursing (DON) was interviewed on 6/2/16, at 11:50 a.m. The DON verified R20's Gabapentin should not have been left on top of the medication cart. The DON said she would expect staff to pour out the dosage of medication prescribed, and to put the bottle back in the refrigerator which was secured. On 6/1/16, at 9:34 a.m. registered nurse (RN)-C (a nurse from the 200 unit) was observed to unlock a medication cart, and place her keys on top while looking for eye drops for R15. RN-C then shut the medication drawer she was looking in, and proceeded around the corner and down the hallway to give R15 eye drops. RN-C did not lock the cart, nor pick up her cart keys prior to walking away from the cart. RN-C returned to the unlocked medication cart at 9:39 a.m. At that time, the surveyor asked RN-C about walking away from the cart which was unlocked and had keys on top. RN-C only acknowledged the question with "uh." During review of the medication cart, it was noted to contain insulin pens, and numerous oral medications for residents. During interview with the DON at 3:30 p.m., the DON verified she'd been made aware RN-C had left the medication cart unlocked with the keys on	21610		

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21610	Continued From page 25 top. The DON verified the medication cart should be kept locked and the keys should be kept with the person responsible for passing medications. The facility policy entitled Acquisition, Receiving, Dispensing and Storage of Medications dated 12/15, indicated: "medication will be stored in a locked medication cart, drawer or cupboard. Only the person passing the medications and the director of nursing services will be permitted to have access to the keys to the medications storage areas." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced	21685		7/11/16

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21685	Continued From page 26 by: Based on observation, interview and document review, the facility failed to maintain kitchen equipment in a clean and sanitary manner to promote sanitation and food safety in the main kitchen. This practice had the potential to affect all 76 residents who received food from the kitchen. Findings include: During the kitchen tour on 5/31/16, at 12:20 p.m. the following sanitation concerns were observed and confirmed by the Director of Dietary (DD): -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 knobs on the flat top griddle were dirty and sticky with a buildup of a brown/black substance. During a follow-up kitchen tour on 6/2/16, at 1:25 p.m. the following sanitation concerns were observed and verified by the DD: - The six burner stove with three sets of two grates had a buildup of a greasy black food debris in the corners of the grates and between each set of grates. The outside of the oven door situated below the stove burner stove had food splatter down the front of it and there was grease and food debris caked on and around the corners of the handle. All six knobs had a heavy buildup of brown/black substance on and around the knobs. - The flat top griddle front plate was covered with a sticky, brown greasy residue with food spills	21685	Acknowledged	

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21685	Continued From page 27 down the front panel of the unit. DD verified both units needed cleaning and although they have a cleaning schedule, she was not sure if the two units were scheduled for deep cleaning. During an interview on 6/3/16, at 10:55 a.m. DD stated the deep cleaning of the stove was not on the cleaning duty list "but it is now." DD verified the deep cleaning duties was the policy and in effect prior to survey. Review of the undated Sunday Cleaning Duties policy did not include cleaning of either the flat top griddle or the six burner stove. Review of the undated Deep Cleaning Duties policy indicated the AM cook was responsible for cleaning the "grill" and the PM cook was responsible for cleaning the "cook's oven and stove top area." The DON or designee, could coordinate with dietary staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. SUGGESTED METHOD OF CORRECTION: The administrator could in-service employees who do cleaning of kitchen equipment on the need to keep it clean and sanitary. Time period for correction: Twenty one (21) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		7/11/16

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21805	Continued From page 28 courtesy and respect for their individuality by employees of or persons providing service in a health care facility. 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 limited physical mobility and directed staff to assist with dressing, grooming, personal hygiene, and transfers using a mechanical stand lift with assistance of two staff. R18's quarterly Minimum Data Set (MDS) dated 3/11/16, indicated she was severely cognitively impaired. R21's care plan dated 9/1/15, indicated she required extensive assist for all ADL's and directed staff to assist with dressing, grooming and personal hygiene, and to transfer R21 with a mechanical stand lift if weak. R21's quarterly MDS dated 3/25/16 indicated she was severely cognitively impaired. 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.	21805	Acknowledged	

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21805	Continued From page 29 R24's annual MDS dated 3/4/16, indicated she was moderately cognitively impaired and a decreased ability to make herself understood or understand others. R24's care plan dated 3/17/16, indicated she had limited physical ability related to hemiplegia and directed staff to assist with dressing, grooming, personal hygiene, and transfers using a mechanical stand lift with two staff. During an observation on 6/3/16, and 6:19 a.m., R24 was dressed and seated at the table on the unit. R24 stated "they get me up too early." At 9:06 a.m., R24 was asleep in a recliner chair in her room. R34's quarterly MDS dated 4/20/16, indicated he was severely cognitively impaired. R34's care plan dated 2/20/16, indicated he required physical assist for dressing, grooming and personal hygiene, including bathing. During an observation on 6/3/16, at 6:33 a.m., R34 was ambulating down the hall with staff toward the shower room. During an interview on 6/3/16, at 9:12:10 a.m., nursing assistant (NA)-M stated she had to wake R34 up every week for his bath. R42's care plan dated 11/12/15, indicated an ADL deficit and directed staff to assist with all activities of daily living and transfer with a total body lift and assistance of two staff. R42's quarterly MDS dated 4/8/16, indicated she was severely cognitively impaired. R43's care plan dated 4/14/16 indicated she required assistance of two staff for all ADL's and	21805		

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transferred using a total body lift. R43's quarterly MDS dated 4/1/16, indicated she was severely cognitively impaired.

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.

R46's care plan dated 5/14/15, indicated an ADL deficit related to hemiplegia and directed staff to assist with dressing, grooming, personal hygiene and transfer with a total body lift and assist of two staff. R46's quarterly MDS dated 4/1/16, indicated she was severely cognitively impaired.

R50's care plan dated 4/7/14 indicated an ADL deficit related to weakness and directed staff to assist with dressing, grooming, hygiene and transfer using a total body lift and assist of two staff. R50's Annual MDS dated 4/22/16, indicated she was severely cognitively impaired.

During an observation on 6/3/16, at 6:57 a.m., R50 was up in her wheel chair and dressed. During an observation on 6/3/16, at 7:40 a.m., R50 was sitting in her wheel chair, sleeping in front of the television.

During an interview on 6/3/16, at 7:00 a.m., NA-O stated she had to wake R50 up and get her dressed because she ate breakfast at 8:00 a.m.

R56's care plan dated 3/20/14 indicated an ADL self-care deficit and directed staff to assist with all activities of daily living. R56's quarterly MDS dated 4/1/16, indicated moderate cognitive impairment.

R65's care plan dated 2/29/16, indicated an ADL self-care deficit and directed staff to assist her

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with dressing, grooming and transfers. R65's quarterly MDS indicated she was severely cognitively impaired.

During an observation on 5/31/16, at 5:51 p.m., a document titled NOC (overnight) gets up was posted at the center nurse's station. The document indicated the following: "R21- 6am, R56 620am, R20- 640am and R34 7am. Two night aides get up two additional residents."

A review of a facility document labeled, Center, dated 6/3/16, listed ten residents with check marks next to their names and six additional names. A review of a facility document titled 11-7, List For Getting Up In AM, and dated 5/23/16, listed six names.

During an interview on 6/3/16, at 6:13 a.m., NA-B stated she gets residents up for the day based on if the call light was going off and who gets a bath. She stated, "I don't like to disturb anyone, so I will get residents washed, dressed, and leave them in bed." NA-B further stated the residents ate at 7:30 a.m., call lights are a priority and then two person transfers.

During an interview on 6/3/16, at 6:45 a.m., NA-C stated she worked the overnight shift. She stated she had a list of six residents that she had to get up in the morning. NA-C stated, "I have to wake them up to get them dressed and washed and in their wheel chairs starting at 5:00 a.m. "

During an interview on 6/3/16, at 7:05 a.m., NA-N stated she worked the night shift. She stated she had a list of residents she had to get up in the morning. She stated if there are two staff on they get up eight people starting around 5:00 a.m. She stated they have to be ready before she leaves

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21805	Continued From page 32 for the day. NA-N further stated, "We wake people up to get them dressed." During an interview on 6/3/16, at 7:09 a.m., registered nurse (RN)-B stated the number of people the night shift gets up varies depending on how many staff are on. She stated staff should be letting residents sleep unless they are a fall risk. RN-B stated she was not aware staff were waking residents up to get them ready for the day. During an interview on 6/3/16, at 7:17 a.m., RN-D stated the list of who gets up early was based on who was awake. She stated she tried to give the night shift staff residents who require assist of one with dressing and transfers. RN-D stated she arrived to work at 5:30 a.m., but she was unaware staff were waking up residents to get them ready for the day and stated, "It is not a practice we encourage." During an interview on 6/3/16, at 7:46 a.m., the director of nursing (DON) stated the night shift has a list of residents at each station who get up early. She stated the nurse manager was responsible for who was on each list and stated between the nurse managers and the overnight charge nurse they set a list which seems realistic. She stated if a resident was cognitively impaired staff may get them up and dressed and put them back into bed. The DON stated the overnight nurse should be monitoring staff to see if they are waking residents up. During an interview on 6/3/16 at 9:12 a.m., NA-M stated she typically woke up several residents every day. She stated she had to wake them up so they can get to breakfast. She stated she had not been told she should let residents sleep until they were ready to get up.	21805		

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21805	Continued From page 33 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." Review of R20's Significant Change MDS Assessment dated 4/29/16, indicated R20 had severe cognitive impairment and was totally dependent upon facility staff for personal cares and activities of daily living. On 5/31/16, at 4:58 p.m. R20 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 door. Licensed practical nurse (LPN)-B then stood over R20 in front of the bathroom door and began to yell at R20 while pointing at an activity assistant (AA)-B "He can't use the machine, we need two people to use the machine and we don't have anyone else." R20 then attempted to get past LPN-B and into the bathroom. R20 began to grab out toward LPN-B. LPN-B yelled at the	21805		

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resident "Don't you hit me, my dear." R20 continued to try to get past LPN-B into the bathroom stating, "I have to pee, that's where I go, I have to pee." LPN-B stated "I know [R20] but I don't have any help." LPN-B directed AA-B to "get help" and AA-B left the memory care unit. R20 then grabbed LPN-B's arm and LPN-B began to yell in R20's face "ouch, ouch, ouch, ouch, ouch" while trying to remove her arm from R20's grasp. Another NA entered the unit, went directly toward R20 and LPN-B and stated calmly to R20 she was "here to help [R20] to the bathroom." R20 let go of LPN-B's arm, appeared calm and was assisted to the bathroom. LPN-B was not observed to write R20 a note of when she would be assisted to the bathroom.

LPN-B was interviewed on 5/31/16, at 5:03 p.m. regarding the incident that occurred with R20. LPN-B stated R20 became "very agitated, very quickly and was grabbing me by the wrists and hands." LPN-B stated "this happens a lot with her."

Interview with the nurse manager RN-C on 6/2/16, at 12:00 p.m. revealed R20 had a history of behaviors and staff was directed to keep R20 on a toileting plan and hand notes to her regarding what time she would be assisted to the bathroom. RN-C stated that she would expect staff to walk away from R20 and reapproach later if R20 was being physically aggressive towards staff. RN-C indicated staff have been trained to work with residents who have behaviors and would not expect staff to treat R20 in a demeaning manor.

The director of nursing (DON) was interviewed on 6/2/16, at 1:00 p.m. and stated all staff receive training on how to care for residents with

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21805	Continued From page 35 dementia and behaviors. The DON further stated she expected staff to follow the care plan for all residents and act in a professional and therapeutic way even with residents who exhibit behaviors. A facility policy titled Good Samaritan Society Resident Dignity, dated February 2013, was reviewed. The policy indicated a purpose of maintaining the dignity of all residents and to assist with respecting and abiding by resident rights. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on dignity and respect. The DON or designee could then interview residents routinely to ensure residents feel their dignity and respect are being maintained. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by:	21810		7/11/16

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	00085	A. BUILDING: _____ B. WING _____	06/03/2016

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21810	Continued From page 36 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: 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 intact cognition, and did not exhibit any behaviors. R49 required extensive assistance of two staff for bed mobility, transfers, and toilet use. R49 was able demonstrate use of her call light upon request. The Care Plan dated 3/17/16, identified R49 was dependent on staff for cares and was able to call for assistance using the call light. The undated Visual/Bedside Kardex report indicated "Resident is able to call for assistance when in pain." On 6/1/13, at 9:03 a.m. resident R49 was observed and interviewed and the call light was not within reach. R49 was sitting in her wheelchair with a tray table attached (for crafts), the wheel chair was sitting at a 45 degree angle to the recliner, and the call light was on the floor on the far side of the recliner. R49 asked to have the call light handed to her, she was then able to use it appropriately and it did function. On 6/3/16, at 11:15 a.m. the Director of Nursing (DON) verified R49 can use her call light, and that it should have been within reach. -At 12:22 p.m. the maintenance man stated, "Even I was taught that if you take a patient into a room, you give them the call light, or if you stop in and they don't have the call light, you give it to them."	21810	Acknowledged	

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21810	Continued From page 37 The facility policy dated September 2012, directed: "Purpose: To ensure resident always has a method of calling for assistance." "Procedure: 3. When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it." SUGGESTED METHOD FOR CORRECTION: The director or maintenance (DM) or designee could develop systems of ensuring consistent call light use which included the routine random testing of call light function. The DM or designee could educate all appropriate staff. The DM could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21810		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where	23010		7/11/16

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23010	Continued From page 38 they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to assure a room call light was functioning for 1 of 35 residents (R107) residing in the facility. Findings include: R107's was admitted to the facility on 5/19/16. The admission Minimum Data Set (MDS) dated 5/25/16, identified R107 had severe cognitive impairment, however was able to be interviewed for Stage I data. The MDS indicated R107 required two person assist for bed mobility and one person assist for all other activities of daily living except eating. The care plan dated 5/20/16, indicated R107 required staff assist to manage bladder/bowel incontinence and was at risk for falls. The care plan indicated staff needed to remind the resident not to bend over to pick up dropped items and encourage the use of a grabber or ask for assistance. On 5/31/16, at 4:24 p.m. the call light in R107's room was observed to be pinned to the sheets on her bed. R107 was sitting up on the edge of the bed, was able to identify and press the call light, which resulted in it being nonfunctional. Nursing assistant (NA)-A and registered nurse (RN)-A verified the call light was not functional, with RN-A	23010	Acknowledged	

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23010	Continued From page 39 stating "I will contact maintenance." 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. During an interview on 6/3/16, at 12:03 p.m. HS stated she conducts quarterly audits on call light functions for each resident and typically a NA or the resident would tell maintenance if it wasn't functioning. The call was logged with maintenance and the director of maintenance would have it fixed. HS stated EA would have the policy. During an interview on 6/3/16, at 12:18 p.m. EA stated "if staff or anybody tells me I replace it." EA stated that staff would call the maintenance Hotline system which started in January and we then address it, except if we consider it an emergency, "we do it immediately, like nonfunctioning call lights." EA verified the facility did not have a written policy. Review of the facility Procedure for Call Light dated September 2012, indicated the purpose was to ensure residents always had a method of calling for assistance but lacked direction on how to report nonfunctioning call lights. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise the facility's system in place to ensure resident call lights are functioning properly. TIME PERIOD FOR CORRECTION:Twenty One (21) days.	23010		

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