Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 3, 2025

Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, MN 56183

RE: CCN: 245595
Cycle Start Date: January 9, 2025

Dear Administrator:

On January 9, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 9, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 9, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WESTBROOK	149 FIRST STREET, BOX 218 WESTBROOK, MN 56183

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/6/25 through 1/9/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/6/25 through 1/9/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55953981 (MN101776), and H55953982 (MN108559). NO deficiencies were cited. H55953980 (MN107707) was also investigated. A related deficiency was cited at F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

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

Electronically Signed | 02/12/2025

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

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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the provider following re-development of an unstageable pressure area for 1 of 1 resident (R2). Findings include: R2's 10/9/24, Annual Minimum Data Set (MDS) assessment identified her cognition was intact, she required extensive assistance from staff for activities of daily living (ADLs), and there were no skin issues identified. R2 had diagnoses of Neurocognitive disorder with Lewy Bodies, urge incontinence, major depressive disorder, anxiety disorder, neuromuscular dysfunction of bladder,	F 686	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual.	2/14/25

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F 686	Continued From page 2 osteoporosis, Parkinson's disease, and a history of falls. She was identified as at risk for pressure ulcers but had no unhealed pressure areas at the time of the assessment. R2 had a pressure relief mattress on her bed and her primary mode of transportation was a wheelchair. Observation and /interview on 1/6/25 at 1:30 p.m. with R2 who pulled up her right pant leg to show a Band-Aid covering the outer aspect of her ankle, and reported she had a sore there, but she did not recall when it had occurred or if she had injured the area. She reported staff put her stockings on over the bandage in the morning and took then off when she went to bed at night. The staff changed the band aid, but she wasn't certain how often they did that. Observation on 1/7/25 at 3:19 p.m., of licensed practical nurse (LPN)-A as she performed wound care to R2's right ankle. LPN-A cleansed the wound area with wound cleanser, applied skin prep to the surrounding area and allowed to dry. The wound had a light pink area surrounding a white, scabbed center area. R2 denied any pain or discomfort in the area. LPN-A applied a new Band Aid to the wound and dated and initialed the area. She reported R2 preferred to lie on her right side and interventions included repositioning and encouraging her to position off her right side. Interview on 1/7/25 at 3:25 p.m. with the director of nursing (DON), reported the medical record identified the wound was noted on 12/28/24, and described as the outer aspect red, and the center was pink with a small, scabbed area. She reported the source was unknown, but R2 had a history of reoccurrence of a right ankle wound. The DON reviewed the record and identified the	F 686	1. The residents affected by the deficient practice were 1 resident out of 1 at the time of survey. For the resident affected we did the following : We measured the area We contacted the provider and received an order The order from the provider stated that we would start skin preparation and use corn pads to protect the area. We will not use her ted stockings and she will not wear a shoe on that foot until the area improves in the healing. The wound was updated on the TAR and wound data collections were started on the resident. 2. We completed a review of the facility residents and made sure that all wounds were addressed correctly and they all had appropriate assessments and orders. 3. We have improved the process to include the following steps: Initial finding on all skin concerns Measure, perform initial first aid Contact the provider using wound fax form Contact the family and document who, how and when the notification was made in PCC. Notify the DNS and or the nurse on call of the wound. Complete an incident report for surgical	

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F 686	Continued From page 3 last wound occurrence was in August of 2024. She reported the wound had healed, and remained healed until it was noted again on 12/28/24. A skin assessment was documented on 12/29/24, but there was no documentation the provider had been notified or orders received for a plan of treatment. She reported the record indicated staff were using skin prep on the area and covering with a band aid for protection. The DON reported she would have expected the provider to be notified of the reoccurrence, furthermore, the provider had made rounds on 12/31/24 with no record of the provider being updated of the reoccurrence of R2's ankle wound. The DON obtained measurements of the wound and reported, the size as .2 centimeters (cm) x .2 cm. on 1/9/25, with the area scabbed with no drainage present. Review of the April 26, 2024, Skin Assessment Pressure Ulcer Prevention and Documentation Requirements Policy identified the registered nurse (RN) was to complete a skin assessment to identify any skin issues. When an area was identified the RN was to record the type of wound, the degree of tissue damage, and the location of the wound, measurements, and the stage for a pressure area. The physician was to be notified of the resident condition and ulcer with orders for treatment documented.	F 686	wounds Open a UDA to be completed daily RN wound assessment should trigger with completion of the wound UDA. Wound will be measured with dressing changes Dietary notified if any pressure injury Determine if a need for therapy evaluation. IDT team to discuss weekly. To ensure systemic changes are sustained, the Director of Nursing will review weekly wound checklists, IDT discussion and ensure that the wounds are being addressed, and correct documentation is completed. The process was updated and all nursing staff were educated on the changes in the process and the new expectations. 4. To ensure compliance is maintained ,daily audits of the wound checklists will be completed daily for 2 weeks, and 100% compliance is achieved. Then audits will be completed twice a week for 2 weeks and 100% compliance is achieved. Then we will move to monthly audits and 100% compliance for 6 months. The Director of Nursing will report audit results to QAPI monthly. 5. Date 2/12/25	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		2/5/25

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F 689	Continued From page 4 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to prevent potential accident hazards for 2 of 2 residents (R7 and R19) due to wandering behaviors into unsecured areas containing hazardous substances. Findings include: R7's, 12/17/24, Significant change Minimum Data Set (MDS) assessment identified she had severe cognitive impairment and wandered throughout the facility including into other resident spaces. R7 had diagnoses of cognitive communication deficit, Cerebrovascular disease affecting left side, anxiety disorder, dementia, and cerebral infarction and wandered within the facility 1-3 days weekly. R19's, 11/27/24, quarterly MDS identified she had severe cognitive impairment, demonstrated verbal and physical behaviors directed toward others, and wandered throughout the facility and into other resident spaces and wandered 1-3 days weekly. Observation on 1/8/25 at 7:33 a.m. noted the tub room door open with no staff in attendance or in the immediate area outside of the tub room. Inside the room located beside the whirlpool tub a white cabinet had both doors open displaying	F 689	1. The residents affected was 1 of of 1 resident. The resident identified in the survey was redirected immediately by a staff member and the door was shut so it locked. The staff then immediately cleaned out the tub chemicals and placed them in the correct locked storage location. They also closed the personal items cabinet immediately and the manager ordered a lock for the door. 2. All residents had the potential to be affected by the deficient practice. 3. To ensure systemic changes are sustained, the tub/spa room has a sign on the door that communicates that the door needs to be shut at all times. The lock has been placed on the cabinet in the tub room. The cabinet in the tub/spa room that holds the personal care items has a lock on the door. The tub cleaning solutions are stored in a locked cabinet in the tub room and extra supplies are kept in a locked room in the facility.	

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F 689	Continued From page 5 personal care products including Skin protectant cream; hand lotion; skin cleaner; brushes; combs; body spray; hair spray; body powder; deodorant; nail files; and an electric razor. A pair of scissors, tweezers and a nail clipper were on the top of the cabinet along with a large jug of Thera Sol and a spray bottle of Rapid Multi disinfectant cleaner. The items were within reach of a resident ambulating or seated in a wheelchair who could enter the room. The removable bath chair base was located on the floor on the other side of the tub and could present a fall risk to a resident on that side of the tub. At 7:35 a.m., R19 was observed transporting herself in her wheelchair as she proceeded into the tub room, looked around and moved toward the cabinet. Unidentified staff were noted to pass by the room and glance in, but failed to investigate what R19 was doing in the unsecured tub room, as they passed by. R19 moved toward the cabinet reaching her hand out, as she was mumbling but was not able to reach the cabinet due to surveyor standing in front of it. R19 continued to move around the room, bumping items with her wheelchair before turning and exiting the room transporting herself down the hall. No staff checked on R19 or questioned what she was doing in the open and unattended tub room. Interview on 1/8/25 at 7:45 a.m. with the administrator reported the tub room should not have been left open and unattended, and the cabinet containing personal care items, in addition to the cleaning products on top of the cabinet should have been secured. The administrator confirmed R19 had severe cognitive impairment and was not aware of safety issues that could have occurred with the items in and on the cabinet.	F 689	The staff were educated on the changes to the tub/spa room and the requirements to keep the cabinets closed and locked and the proper way to store tub chemicals. They were also trained in the requirements to keep the door to the tub/spa room closed at all times. 4. To ensure compliance is maintained, daily audits of the tub/spa room will be done daily for 2 weeks, and 100% compliance is achieved. Then audits will be done twice a week for 2 weeks and 100% compliance is achieved. Then we will move to monthly audits and 100% compliance for 6 months. The operations manager will report out monthly on the audits at the facility QAPI meetings. 5. 2/5/25 1. The door to the maintenance room was closed immediately and a sign placed on the door that the door needs to be closed at all times on A keyless entry touch pad has been installed that same day in the door and a hinge that will close the door behind anyone who leaves the room on All chemicals were removed and placed in the approved storage area which is locked. All tools are now placed in the tool cabinets which are locked was completed the same day.	

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F 689	Continued From page 6 Observation on 1/6/25 at 12:20 p.m., a room at the end of the 300-wing hallway across from a sitting area had an open door. Inside the room was a desk against the wall. The desk had 2 bottles labeled Drano (a toxic solution used for clogged drains), a cart next to the desk had 2 cans labeled WD-40 (a flammable solvent), on the bottom shelf of another utility cart was a box labeled Terro (a pest control solution), an aerosol can labeled Lysol (disinfectant spray), an aerosol can labeled Zinsser Bulls-Eye 123 Primer, and multiple hand held tools including drills, drill bits, and screw drivers. Interview on 1/6/25 at 12:44 p.m., with NA-(A) identified they do have 2 residents who wander. R7 likes to walk up and down the hallways and R19 likes to sit by the doors at the end of the 300-wing (across from the above mentioned room). They both have a diagnosis of dementia. Observation on 1/6/25 at 12:50 p.m., unsecured room containing chemicals remains open, no residents or staff were observed in the area during the observation. Interview on 1/6/25 at 12:50 p.m., with the administrator identified the door should always be locked. She agreed there are toxic chemicals in the room that need to always be secured for the safety of the residents and any children that may be visiting the facility. She further identified that the facility has residents with diagnosis of dementia that could be at risk. The maintenance director was unavailable for	F 689	The maintenance personnel had documented counseling on the requirements and expectations of handling chemicals and tools in the facility. 2. All residents had the potential to be affected but the deficient practice. 3. To ensure systemic changes are sustained, all chemicals and tools which could have the potential to cause harm are now locked up in the approved areas in each location. The correction in the maintenance office will eliminate all access to the maintenance room, chemicals and tools. All staff have been trained on the safe chemical handling policy. 4. To ensure compliance is maintained, daily audits of maintenance room will be done daily for 2 weeks, and 100% compliance is achieved. Then audits will be done twice a week for 2 weeks and 100% compliance is achieved. Then we will move to monthly audits and 100% compliance for 6 months. The operations manager will report out monthly on the audits at the facility QAPI meetings. 5. 2/5/25	

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F 689	Continued From page 7 interview. Review of the undated Procurement and Storage of Equipment, Products, and Supplies policy identified the facility was to ensure that all chemicals and disinfectants are labeled and stored in a manner that eliminates risk of improper use, contamination, inhalation, skin contact or personal injury. Housekeeping products and supplies should not be stored in resident rooms or units. Store these items in a locked cabinet and/or storage rooms as appropriate.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		2/12/25

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F 756	Continued From page 8 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure that consultant pharmacist reviews were completed monthly for 3 of 5 residents (R10, R19, and R21) reviewed for unnecessary medications. Findings include: R21's 10/30/24, quarterly Minimum Data Set (MDS) assessment identified R21 had severe cognitive impairment, and had behaviors of wandering, exit seeking, and verbal and physical agitation toward staff. She required extensive assistance with activities of daily living (ADLs). R21 ambulated using a 4 wheeled walker with assistance of staff and was seen by therapies. She had pain due to a pelvic fracture because of a fall and received both scheduled pharmacological and non-pharmacological pain interventions. R21 had diagnoses of Alzheimer's disease, major depressive disorder, pain in her feet, dementia, anxiety disorder, and adult	F 756	1. The residents affected by the deficient practice were 3 at the time of survey. We obtained the pharmacy reviews on 1/10/25 from the pharmacist and the provider reviewed them at the time. Changes requested were addressed immediately at the facility. 2. All the residents had the potential to be affected by the deficient practice. 3. To ensure systemic changes are sustained we have completed the following items: On 2/1/25 we started with a new pharmacist that will take over the pharmacy services for the facility. We have started the following new process: On the 25th of each month the pharmacy	

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F 756	Continued From page 9 personality disorder with behaviors. R21 received scheduled medications including an antipsychotic, antidepressant, and antianxiety. Safety measures were identified due to attempts to self-transfer and repeated falls. R21's monthly consulting pharmacist reviews between July through December 2024, identified there had been no documented pharmacist review completed for the months of November and December 2024. R19's 11/27/24, quarterly Minimum Data Set (MDS) assessment identified her cognition was severely impaired, she required extensive assistance with activities of daily life (ADL's) and had verbal and physical behaviors directed towards others, rejected care and at times wandered throughout the facility. R19 had diagnosis of dementia, aphasia, anxiety, and depression and was taking psychotropic medications for depression and anxiety. R19's monthly consulting pharmacist reviews between July through December 2024, identified there had been no documented pharmacist review completed for the months of November and December of 2024. R10's 12/23/24, quarterly Minimum Data Set (MDS) assessment identified R10's cognition was intact. R10 had some verbal behaviors directed towards others and required extensive to total assistance with cares. Daily he received insulin, an anticoagulant, diuretic, antidepressant, and	F 756	reviews will be completed and sent to the Director of Nursing and the Infection Preventionist at the facility. The facility will review and then send the pharmacy reviews to the Provider by the 26th of each month. The provider will review and make any needed changes and return them to the facility by the 28th of each month. If the date falls at the weekend the due dates will move to the next business day. We have also added a backup person to the process with including the Director of Nursing so that in case we have someone gone that someone is always working the process and reviewing the documents. Staff were educated on the new process and in two mandatory staff meetings the process will be reviewed at weekly IDT meetings. 4.To ensure compliance is maintained, daily audits of the pharmacy reviews will be done monthly for 6 months and 100% compliance is achieved. Audits will be reported by the Director of Nursing at the monthly QAPI meetings. 9. 2/12/25	

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F 756	Continued From page 10 antipsychotic medication. The assessment identified diagnoses of hypertension, diabetes, hyperlipidemia, stroke, bilateral weakness, seizure disorder, and depression. R10's monthly consulting pharmacist reviews between July through December 2024, identified there had been no documented pharmacist review completed for the months of November and December 2024. Interview on 1/8/24 at 10:12 a.m., with administrator identified that the facility had concerns with the consulting pharmacist, and she had reached out to national campus who was also working with the pharmacist. The facility had trouble getting pharmacy reviews completed timely and they had discussed switching back to Thrifty White. She believed that the reviews had been completed but the facility did not have a copy in house of the review. Not being provided the reviews consistently was a problem for being able to communicate the recommendations to the provider. The facility was consistently calling the pharmacy and asking for the information. Additionally, she reported that she had tried to reach out to the pharmacist however, the pharmacist was out ill and unavailable. The pharmacist was unavailable for interview. There was no pharmacy contract provided during the survey.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		2/10/25

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F 757	Continued From page 11 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to investigate and/or document the justification for a prophylactic antibiotic for 1 of 1 resident (R7). Findings include: R7's 12/17/24, Significant change Minimum Data Set (MDS) assessment identified she had severe cognitive impairment and wandered throughout the facility including into other resident spaces. R7 had diagnoses of cognitive communication deficit, Cerebrovascular disease affecting left side, anxiety disorder, vascular dementia, and cerebral infarction. R7 was frequently incontinent of bowel and bladder and required staff assistance for toileting.	F 757	1. The deficient practice affected one resident at the time of the survey. The resident identified in the survey had her medication reviewed and discontinued on 1/8/25. The prophylactic antibiotic was discontinued immediately on 1/8/25. 2. All residents had the potential to be affected by the deficient practice. We have completed a review of all residents to ensure they are not receiving a prophylactic antibiotic. A review of all residents currently receiving an antibiotic was conducted to	

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F 757	Continued From page 12 R7 was admitted in November of 2024, with orders for Macrobid (antibiotic)Capsule 100 milligrams (mg) by mouth (PO) daily (QD) with the diagnosis of chronic urinary tract infection (UTI). A urine test was completed 11/13/24 with negative results, and no culture and sensitivity was completed. There was no documentation to support the reason for the urine test, or any signs and symptoms (S/S) the resident had displayed. The preadmission assessment dated 11/5/24 by the MD, contained documentation R7 was receiving Macrobid 100 mg PO QD at 8:00 p.m., but there was no identified start or stop date, nor rational identifying a reason for prophylactic use of an antibiotic. R7's current undated care plan identified she had bowel and bladder incontinence related to vascular dementia, weakness, hallucinations, confusion, was at risk for falls, and low blood pressure. R7 had a history of frequent UTI's. Interventions included encouraging fluids during the morning and afternoon, monitor for S/S of UTI's, and offer toileting/repositioning Q 3 hours (H). There was no mention of R7 receiving a prophylactic antibiotic. Interview on 1/6/25 at 4:42 p.m. with licensed practical nurse (LPN)-B reported R7 was currently receiving a prophylactic antibiotic Macrobid 100 mg PO Q HS for chronic UTI's, with an original order date of 11/6/24 and no end date ordered. Interview on 1/7/25 at 11:14 a.m., with nursing assistant (NA)-A reported she was aware of the S/S of a UTI and would immediately report them to the charge nurse. She reported she had	F 757	ensure an 48 hour time out was completed. 202 residents were identified and they both had the 48 hour time outs completed. 3. To ensure that systemic changes are sustained, the corrected process will be the following: The admission and readmission process and checklist have been updated to show that all orders will be reviewed at the time of admission. The orders in question will be discussed at the weekly IDT meetings. The Antibiotic stewardship team will meet monthly and review the orders and report on all antibiotic medications. All findings will be reported out at the monthly QAPI meeting each month. All staff received training on the new process and Antibiotic Stewardship at a mandatory staff meeting. 4. To ensure compliance is maintained, daily audits of residents Antibiotic Medications will be done daily for 2 weeks, and 100% compliance is achieved. Then audits will be done twice a week for 2 weeks and 100% compliance is achieved. Then we will move to monthly audits and 100% compliance for 6 months. All results will be reported out at the QAPI meetings monthly 5. 2/10/25	

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F 757	Continued From page 13 frequently assisted R7 with toileting and was not aware of any S/S of a UTI. Interview on 1/7/25 at 3:43 p.m. with the director of nursing (DON) identified R7 had been admitted with an order for a prophylactic antibiotic for recurrent UTI's. She was not aware of any evaluation for the need to continue the prophylactic antibiotic, or investigation taking place to identify the need for R7 to remain on the antibiotic. Interview on 1/8/25 at 1:25 p.m. with R7's primary provider (medical director) reported he was not certain when R7 had initially been started on Macrobid for a diagnosis of recurrent UTI's, but it had been prior to admission to the facility. The MD reviewed R7's clinic record and reported the original order was dated October of 2023 and she had been receiving the medication since that time. He had not investigated the continued need for the antibiotic at the time of admission, nor had R7 experienced any identified S/S of a UTI since time of admission. R7 had been admitted from an Assisted Living situation and was likely receiving better personal care currently than she had been able to provide for herself in her previous living situation. He was not aware of any previous referral to urology or infectious diseases and the continued use of the prophylactic antibiotic would need to be investigated further. The MD noted continued use justification should be brought forward for discussion with the MD if criteria was not met. Interview with the Infection Preventionist on 1/8/25 at 2:31 p.m. identified she was aware R7 was receiving a prophylactic antibiotic, but she had not identified this as an area of concern to	F 757		

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F 757	Continued From page 14 investigate further under antibiotic stewardship criteria. A policy for unnecessary medications, and/or use of prophylactic antibiotic use was requested but not provided by the end of the survey period.	F 757		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to appropriately prepare unpasteurized eggs, monitor temperatures of food prior to serving, and to monitor the refrigerator and freezer temperatures to prevent food borne illnesses. Findings include:	F 812	1. Residents affected were 3 residents at the time of the survey. The unpasteurized eggs were immediately removed from the kitchen and tagged to no longer be used on 1/8/25. Immediately pasteurized eggs were obtained for use in the dietary department.	1/31/25

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F 812	Continued From page 15 Observation and interview on 1/6/25 at 10:52 a.m., with the dietary manager (DM) during a tour of the kitchen, the DM identified the eggs located in the refrigerator in the prep area were unpasteurized. The DM reported that the facility cooked the unpasteurized eggs "hard". She further reported she had forgotten to provide temperature monitoring sheets for the month of January, and temperatures had not been monitored and documented for the refrigerators and freezer. She confirmed that the refrigerator and freezer temperatures were to be monitored twice a day. Interview on 1/7/25 at 7:58 a.m., with the DM identified she ordered eggs through Sysco, and pasteurized eggs were not available at the time of the order. She stated she was aware that the unpasteurized eggs were to be cooked "hard" as they could not be served with a "soft" yoke. Review of the current facility menu identified eggs for breakfast: Week 1-Sunday scrambled eggs, Monday no eggs, Tuesday no eggs, Wednesday egg of choice, Thursday scrabbled eggs, Friday egg of choice, and Saturday no eggs. Week 2- Sunday cheesy eggs, Monday no eggs, Tuesday no eggs, Wednesday scrambled eggs, Thursday no eggs, Friday scrabbled eggs, and Saturday no eggs. Week 3-Sunday egg of choice, Monday cheese omelet, Tuesday no eggs, Wednesday scrambled eggs, Thursday cheese and egg casserole, Friday egg of choice, and Saturday no eggs. Week 4-Sunday egg and cheese sandwich, Monday no eggs, Tuesday scrambled eggs, Wednesday no eggs, Thursday egg of choice,	F 812	2. All residents had the potential to be affected by this deficient practice. 3. To ensure systemic changes are sustained, pasteurized eggs were ordered from the vendor, and liquid eggs will be ordered and used in times of any shortages going forward. All current staff have been trained on the policies and procedures of food safety. The Sysco company will be made aware of our requirements for pasteurized eggs and note the record at their system that we cannot order or be sent unpasteurized eggs and liquid pasteurized eggs need to be substituted. 4. To ensure compliance is maintained, daily audits of the temperature of the refrigerator, freezers and food that is served will be done daily for 2 weeks, and 100% compliance is achieved. Then audits will be done twice a week for 2 weeks and 100% compliance is achieved. Then we will move to monthly audits and 100% compliance for 6 months. The audits will be reported out at the monthly QAPI meetings. 5. 1/31/25 1. The temperature logs for the refrigerators,	

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F 812	Continued From page 16 Friday cheese omelet, and Saturday no eggs. Observation on 1/7/25 at 9:07 a.m., during medication pass, R5's plate was observed to have what looked like yellow egg yolk smeared on about ¼ of the plate and on the plates raised edges. There were two other residents in the dining room eating scrabbled eggs with no indication of egg yolk on their plates. Interview on 1/8/25 at 7:47 a.m., with dietary cook (C)-A who identified residents can get their eggs scrabbled or over easy. If she made scrambled eggs, she used the liquid eggs from the carton and for the over easy eggs she used the eggs out of the refrigerator. She reported she was unaware if the eggs were pasteurized or unpasteurized. She revealed she had not received any education on the use of pasteurized or unpasteurized eggs and how to prepare them. She reported R27 had requested "runny" eggs this morning and she made them runny for her. She then revealed that R5, R25, and R26 also requested their eggs runny sometimes. She then said, she believed the eggs were unpasteurized and that they had been getting the unpasteurized eggs for a while now. She reported she was unaware unpasteurized eggs needed to be "hard" cooked and not served "runny". Interview on 1/8/25 at 7:54 a.m., with the dietary assistant (DA)-B identified that he did not cook, and he had not had any training on handling unpasteurized eggs. He confirmed there were residents in the facility who liked their eggs "runny" or "soft" for breakfast. Interview on 1/8/25 at 8:13 a.m., with R5 identified she liked eggs, and she usually ordered	F 812	freezers and food temperatures were corrected immediately on 1/8/25. We immediately placed the temperature logs were placed on the refrigerators, freezers and by the steam table in the kitchen. 2. All residents had the potential to be affected by this deficient practice. 3. To ensure systemic changes are sustained, all the dietary staff were educated on the purpose for the temperature logs and the expectations of completing them per policy with the following items Food Temperatures will be recorded and taken prior to each meal. Periodic food temperatures will be during or at the end of the meals to ensure temperatures maintain the acceptable ranges. Freezer temperatures will be taken and recorded twice a day. Refrigerator temperatures will be taken and recorded twice a day. All food temperature logs will be kept in the dietary managers' office for seven years and organized by date and year. The dietary manager was counseled on 1/8/25 the missing temperature logs in the three areas of the kitchen and the expectations that she follows the policy immediately. 4. To ensure compliance is maintained, daily audits of the temperature of the refrigerator, freezers and food that is	

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F 812	Continued From page 17 them fried, but did occasionally like them soft but not runny. Interview on 1/8/25 at 8:16 a.m., with R26 identified he liked eggs. He was unable to tell how he liked or received his eggs. Interview on 1/8/25 at 8:20 a.m., with the director of nursing (DON) identified the dietary manager ordered the eggs for the facility. She reported that if the facility had unpasteurized eggs, she would expect the dietary staff to be trained on handling unpasteurized eggs. Interview on 1/8/25 at 8:24 a.m., with the administrator identified unpasteurized eggs should not be served "runny" and she would expect all dietary staff to know how to handle unpasteurized eggs. She was unaware that the facility had been getting unpasteurized eggs and stated the facility should only be ordering pasteurized eggs. She then picked up the phone and called the dietician and the dietician stated on speaker phone the only time the facility should use unpasteurized eggs was if it was for baking. The dietician further reported if unpasteurized eggs were to be used for breakfast that they had to be cooked hard and all staff should be trained on how to handle unpasteurized eggs. Interview on 1/8/25 at 8:39 a.m., with DM identified she was still unable to get pasteurized eggs and she had forgotten to tell C-A the unpasteurized eggs could only be served cooked hard. For residents who like them served soft she reported they were to explain to the resident that they could not make soft eggs at this time and offer to serve the eggs hard or scrabbled. She said when she went to order the pasteurized eggs	F 812	served will be done daily for 2 weeks, and 100% compliance is achieved. Then audits will be done twice a week for 2 weeks and 100% compliance is achieved. Then we will move to monthly audits and 100% compliance for 6 months. The audits will be reported to the QAPI team monthly. 5. 1/31/25	

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F 812	Continued From page 18 from Sysco they were listed out of stock. She stated, "I'm not going to try to pull the wool over your eyes or lie" and confirmed she had not been monitoring the temperatures for the food, refrigerators, or freezer. She reported she knew the refrigerator and freezer were working and she had set a bad example for others. She confirmed she knew she was supposed to monitor and document but she just did not do it. She said she had let a lot of things go that she was supposed to do but she had been working 7 days a week for a very long time and she just let things go. She confirmed she had no temperature logs to provide for food monitoring, refrigerators, or freezer. Interview on 1/8/25 at 9:18 a.m., with the dietician identified she would expect staff to monitor and document food temperature prior to serving, in addition to monitoring refrigerator and freezer temperatures. She reported she was surprised that it had not been getting completed. She was unaware that anyone was having trouble getting pasteurized eggs. Interview on 1/8/25 at 9:35 a.m., with the Sysco customer care identified there had been a problem with obtaining pasteurized eggs at some warehouses. He revealed that his records showed pasteurized eggs were unavailable at time of the facilities November and December orders. Facilities are not allowed to use unpasteurized eggs and other facilities had been ordering liquid eggs. He was unsure why the pasteurized eggs were unavailable and said Sysco was at the mercy of what they could get in the warehouses, but it appeared to be resolved at this time.	F 812		

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F 812	Continued From page 19 Interview on 1/8/25 at 10:12 a.m., with the administrator identified she had all the unpasteurized eggs removed from the building, she set up mandatory education for dietary staff prior to starting their shift and arranged for the dietician to come today to re-educate the dietary manager. Interview on 1/8/25 at 1:21 p.m., with the medical director identified he would expect the facility to be following policies and procedures for monitoring and documenting food temperatures, refrigerator, and freezer temperatures to prevent food borne illnesses. He further confirmed unpasteurized eggs should not be served soft or runny due to the risk of Salmonella illness. Review of 12/16/24, Food Temperature Monitoring policy identified food temperatures are to be taken and documented prior to each meal. Additionally, periodic temperatures should be taken during or at end of meal to ensure temperatures maintain acceptable ranges. Review of 5/7/24, Food-Supply Storage-Food and Nutrition policy identified all refrigerators and freezers in the nutrition department and dining room are recorded twice daily. Review of 3/11/24, Ordering-Food and Nutrition Service policy identified ordering food will be completed timely and can be completed by ordering through Food Samaritan NET Purchasing System (DSSI) or by ordering directly from the vendor. If questions or concerns staff should reach out by submitting question directly to Sanford Service Portal, or by contacting National Campus.	F 812		

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F 812	Continued From page 20 A policy for use of unpasteurized eggs was requested but not provided.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		2/14/25

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F 880	Continued From page 21 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to have a current, ongoing, system of surveillance to identify potential outbreaks of infectious disease, ensure transmission based precautions were implemented timely, perform root cause analysis to identify patterns of illness in staff or residents,	F 880	1. The Infection Prevention Specialist, or appointed designee, will complete routine infection surveillance of residents and document in the infection tracking application, as well as employees and document on the employee illness log.	

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F 880	Continued From page 22 report an outbreak of Norovirus (highly contagious gastrointestinal (GI) virus that causes inflammation of the stomach and intestines), prohibit staff from returning to work until 72 hours from resolution of gastrointestinal symptoms occurred. and ensure 1 of 1 whirlpool tub was appropriately disinfected between resident use according to the manufacturer's directions. This had the potential to affect all 29 residents. Findings include: SURVEILLANCE/ POTENTIAL NOROVIRUS OUTBREAK Review of the September 2024 Monthly Infection Control Report identified 14 antibiotic orders utilized with 231 days of therapy. No staff/family/visitor documentation of illness was provided/identified in the document. Nine residents (R3, R5, R11, R17, R19, R24, R31, R182 and R183) were identified as having received antibiotics. 1 resident (R17) was identified as started on Paxlovid (antiviral medication used to treat COVID-19 symptoms). There was no documentation on the surveillance of a positive COVID diagnosis, date of initiation of S/S, transmission-based precautions (TBP) implemented, with start and stop dates, nor investigation into potential contacts or source of infection. Review of the October 2024, Monthly Infection Control Report identified 10 antibiotic orders utilized with 100 days of therapy. The report identified a COVID outbreak in the facility with 14 residents identified as COVID positive from September were carried over (R5, R9, R10, R14, R17, R22, R23, R24, R31, R133, R134, R185,	F 880	Surveillance data and documentation will be reviewed by the Infection Prevention Specialist, or appointed designee, to ensure transmission-based precautions are implemented for residents, work restriction guidelines are implemented and adhered to for employees, and potential outbreaks are identified and reported to public health authorities according to state-specific guidelines. The DNS will complete training to provide secondary oversight of the infection prevention program. Employees who provide bathing services will be educated on cleaning and disinfection of the whirlpool tub according to manufacturer s recommendations. 2. All residents had the potential to be affected by this deficient practice. 3. to ensure systemic changes are sustained, the Infection Preventionist, or appointed designee, will report infection surveillance of residents and employees (to include TBP, work restrictions, and outbreak identification and reporting) to the weekly IDT meeting, as well as the monthly QAPI committee. The location will implement a whirlpool cleaning and disinfection checklist to document compliance. All nursing staff were educated on the manufacture cleaning and disinfection procedure and the instructions and reference sheet are located by the tub for the staff to refer to as needed.	

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F 880	Continued From page 23 R186 and R189). One resident (R31) was identified as having COVID and was also receiving an oral antibiotic without documented rational to support treatment for a bacterial infection. One resident was identified to be positive for Norovirus (R11) on 10/14/24, and 5 other residents (R1, R8, R17, R18, and R19) were listed as having "GI" symptoms on 10/21/24 through 10/26/24. Three residents, R2, R8, and R11, had documented urinary tract infections (UTI). The employee/children/family/visitor log for October 2024 identified 10 staff and/or their family members: 1) Nurse aide (NA)-C tested positive for COVID with onset of symptoms beginning 10/4/24 and returned to work when a negative COVID test was obtained on 10/9/24. 2) NA-D reported nausea and being sweaty on 10/11/24 and returned to work on 10/13/24. 3) Trained medication aide (TMA)-A reported nausea and vomiting on 10/13/24 and returned to work 10/15/24. 4) Licensed practical nurse (LPN)-B reported vomiting and diarrhea also on 10/13/24 and returned to work the next day on 10/14/24. 5) NA-E reported vomiting and diarrhea on 10/23/24 and 10/24/24 and returned to work on 10/31/24. 6) NA-F reported vomiting and diarrhea 10/15/24 through 10/16/24 and returned to work 10/18/24. 7) Unidentified staff (U)-A reported they along with their child had symptoms of fever, vomiting, and diarrhea. There was no notation if or when that staff reported back to work. 8) NA-G and their child reported vomiting and/or diarrhea on 10/16/24 and 10/17/24. NA-G returned to work on 10/20/24.	F 880	To ensure infection control surveillance of staff related illnesses documented and reported appropriately. All nursing staff have been trained on the correct process to utilizing absence and tardy forms including signs and symptoms of illness. Facility wide staff to utilize absence and tardy forms for all staff illness including signs and symptoms of illness. All staff have been educated on the importance of infection control surveillance reporting including signs and symptoms of staff illness. As well as how they impact the residents potential infections. 4. To ensure compliance is maintained, the DNS, or appointed designee, will complete audits of infection surveillance documentation and follow up twice per week x two weeks, then weekly x two weeks, then monthly x three months. The DNS, or appointed designee, will complete audits of whirlpool cleaning and disinfection checklist twice per week To ensure the proper process is being completed. twice per week x two weeks, then weekly x two weeks, then monthly x three months. Audit results will be reported to the QAPI committee monthly. 5. 2/12/25	

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F 880	Continued From page 24 It was noted some staff symptoms were documented as resolved, but not the date they resolved, or if staff had been prevented from returning to work for 72 hrs. after GI symptoms resolved. It is also not identified the infection preventionist correlated the possibility of staff being infected with Norovirus after R11 was formally diagnosed with the infection on 10/14/24, or the other residents, who had not been tested for potential Norovirus but had similar symptoms of potential outbreak had been noted. There was also no mention when TBP were implemented, or if any had occurred, or what type. Review of the November 2024, Monthly Infection Control Report identified 16 antibiotic orders utilized with 75 days of therapy. The report identified 1 resident (R7) admitted on a prophylactic antibiotic for history of UTI's. The record failed to contain any investigation into the continued need or rational for continued use of the antibiotic or if a time-out had been performed. 12 residents received antibiotics in November (R6, R7, R13, R15, R17, R18, R23, R24, R27, R187, R188, and R189). The employee/children/family/visitor log for November 2024 identified: 1) An unidentified staff (U)-B had s/s of a sore throat and cough on 11/13/24, tested negative for COVID and returned to work 11/15/24. 2) NA-I had "GI Illness at work" on 11/1/24 and went home. NA-I was noted as working less than part time, however, there was no notation to show if or when NA-I returned to work in November 2024. 3) LPN-C reported s/s of migraine on 11/15/24, but was not tested for COVID as they were positive for COVID infection in September 2024.	F 880		

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F 880	Continued From page 25 4) NA-C reported vomiting on 11/21/24, noted as "symptom free" and returned to work the next day on 11/22/24. 5) NA-J reported fever and vomiting on 11/21/24, and returned to work the next day on 11/25/24. 6) NA-G had an ill child from 11/12/24 through 11/14/24 and "took to MD [doctor]". NA-G returned to work on 11/18/24. It was noted some staff symptoms were documented as resolved, but not the date they resolved, or if staff had been prevented from returning to work for 72 hrs. after GI symptoms resolved. It is also not identified the infection preventionist correlated the possibility of staff being infected with potential Norovirus. There was also no mention when TBP were implemented, or if any had occurred, or what type There was no surveillance performed during the month of December 2024 for residents or staff. Review of the 2024-2025 Norovirus Information for Long-term Care Facilities, located at https://www.health.state.mn.us/diseases/foodborne/outbreak/facility/ltcfnorotoolkit.pdf, identified Norovirus is transmitted through a fecal (stool)-oral route with symptoms of diarrhea, vomiting, nausea, abdominal pain, low grade fever, headache, and or body aches. Individuals generally become ill 12-48 hours after exposure (swallowing Norovirus). Infected individuals shed the virus in their stool and contaminate food, surfaces, and objects and can be shed in the stool for several weeks after recovery. Products used to clean Norovirus must say they are effective against Norovirus. Hand sanitizer does not work to kill the virus. Individuals should wash their hands for 20 seconds with soap and water. Individual cases of Norovirus are not reportable to	F 880		

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F 880	Continued From page 26 the State, however, possible outbreaks or multiple cases with Norovirus-like symptoms must be reported. Documentation of possible outbreaks was to include: 1) Use the RESIDENT ILLNESS LOG and STAFF ILLNESS LOG to document illnesses among staff and residents/patients · Contact managers of each unit, etc. as necessary to gather illness information. Send both ILLNESS LOGS back to MDH within 2 business days of reporting the suspected outbreak. · Epidemiology staff will use this to assess A) which pathogen is causing the outbreak, B) the likely route of transmission, and C) whether additional prevention measures are needed. 2) Gather additional information · List activities, events, etc., held during the week prior to the first illness (especially if food was served). · Determine when and where there were any vomiting incidents or diarrheal accidents in the facility. · If requested by MDH, provide a dietary menu (breakfast, lunch, and dinner). · If requested by MDH, provide names and phone numbers for staff and/or residents (in rare cases, MDH may want to conduct interviews). 3) Collect a stool sample from three (3) residents and/or staff and send to MDH Laboratory for analysis (MDH will provide specimen collection kits; the testing is free of charge). · If stools from residents or staff were sent to a clinical laboratory, notify MDH of any results.	F 880		

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F 880	Continued From page 27 4) Send both completed ILLNESS LOGS back to MDH between 1 and 2 weeks after the last illness. 5) IMPLEMENT OUTBREAK CONTROL MEASURES: · Monitor for resident illness (record on RESIDENT ILLNESS LOG) and when possible, isolate residents while they are ill and for 72 hours after symptoms have stopped. Consider halting new admissions until the outbreak has ended. Exclude actively ill residents from games/activities where touching common items occurs (e.g., checkers, cards). · Monitor for staff illness (record on STAFF ILLNESS LOG) and restrict ill staff/volunteers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has ended. Interview and document review on 1/8/24 at 2:10 p.m., with the infection preventionist (IP) identified 1 resident (R11), began having gastrointestinal (GI) symptoms of vomiting and diarrhea on 10/10/24 which continued resulting in her being transferred to the Emergency Department (ED) on 10/14/24 where she was diagnosed with Norovirus and was hospitalized. Beginning on 10/11/24, the October Infection Summary identified staff members and residents who reported ill with symptoms of vomiting and diarrhea. The facility also experienced an outbreak of COVID which documented as beginning 9/21/24 and extending through October 2024 with 13 residents (R5, R9, R10, R14, R17, R22, R23, R24, R31, R 133, R 185, R 186, and R 189), who were identified as positive for COVID during that time. The IP logged the illness for R11 which was diagnoses as Norovirus but had not	F 880		

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F 880	Continued From page 28 done further investigation to identify potential contacts or the potential source of the infection. She had not identified the possible correlation of R11 being diagnoses with Norovirus, and staff members and residents becoming ill with the same type of gastrointestinal (GI) symptoms. The IP identified that due to multiple residents being COVID positive residents were isolated in their rooms, and the facility was not having group activities or dining. Review of the logs for the 2-week period following 10/14/24 Norovirus diagnosis did not identify any additional residents or staff with symptoms of nausea, vomiting or diarrhea. The IP acknowledged there was no surveillance for December 2024. The IP reported she collected infection control data and prepared a summary report at the end of each month that was presented at the QAPI meetings. The IP received both electronic (if the documentation was "completed correctly"), and verbal notifications from the nursing staff when a resident had an infection, and/or there was a positive culture and sensitively result and/or when they were started on an antibiotic. The IP stated she had been on vacation and had not completed the December tracing information at the time of survey and agreed she had not performed daily, cumulative infection control surveillance. There was no mention of any staff member covering the IP duties while she was away from the facility. Review of the infection control logs for residents from September 2024 through November 2024, (December had not been completed), failed to document the resolution of the identified infection following the use of antibiotic treatment, nor was there investigation documented as to potential contacts, or sources of the infection. The employee logs of illness September 2024 through	F 880		

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F 880	Continued From page 29	F 880		

November 2024 (December not available), failed to investigate the potential illness and ensure the employees remained off duty for 48-72 hours following the resolution of signs and symptoms.

WHIRLPOOL
Observation on 1/8/25 at 9:16 a.m. with nursing assistant (NA)-B as she performed cleaning and disinfection of the "Air Spa Advantage Bathing System". NA-B followed the manufacture's posted instructions for cleaning the tub, chair and cushions and rinsing surfaces, however, she failed to ensure the interior surfaces of the tub and chair remained wet for 10 minutes per the manufacturer's instructions.

Interview on 1/8/25 at 10:00 a.m. with NA-B reported she had read the posted direction for cleaning and disinfecting the tub and noted the direction for the surface to remain wet for 10 minutes with the disinfectant but was not aware of "how" she could do that. She had not been trained to ensure surfaces remained wet with disinfectant and stated that was the way "everyone did it".

Interview on 1/8/25 at 1:25 p.m. with the medical director identified his expectation for infection control documentation to be complete and investigation into potential root cause, and or contact with other persons to be documented following an outbreak or infectious virus. He reported he would need to investigate the Infection Control process further as the medical director.

Interview on 1/9/25 at 9:43 a.m., with the director of nursing (DON), reported she was not aware of any potential correlation between the resident

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F 880	Continued From page 30 diagnosed with Norovirus, and other residents and staff beginning to report similar symptoms. Her expectation was for the IP to report any potential contagious conditions to be investigated, interventions implemented, surveillance implemented with appropriate documentation by the IP. The DON was interviewed related to the jetted tub and confirmed her expectation for the jetted tub to be disinfected according to the manufacture's direction listed in the manual and the posted direction on the surface of the tub. She was unaware staff were not following the direction of ensuring a wet contact time of 10 minutes in order to appropriately disinfect the whirlpool tub time and would need to provide re-education to staff to correct the issue. Interview on 1/9/25 at 9:50 a.m., with the administrator reported she was not aware of the tub not being disinfected correctly and expected staff to follow the instructions as listed in the manual. She was also unaware of a possible correlation between other staff and resident illness and the resident that had been diagnosed with Norovirus. The IP had been on vacation and failed to identify anyone designated to cover infection control surveillance. The administrator would expect potential outbreaks to be reported to the State Agency. Review of the 12/2/24, policy Definitions of Infection-For Surveillance Purposes only identified the presence of new GI symptoms in a single resident could prompt increased surveillance for any additional residents with symptoms that could indicate additional cases or outbreak. If an outbreak was suspected stool specimens were to be collected and sent to the lab to determine the presence of Norovirus or	F 880		

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	245595	A. BUILDING _____ B. WING _____	C 01/09/2025

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F 880	Continued From page 31 other contagions. Norovirus Gastroenteritis-if laboratory confirmation is not available, an outbreak (two or more cases in a nursing home) due to Norovirus infection can be assumed present if: 1) vomiting in more than half of residents, 2.) incubation period of 24-48 hours. 3) duration of illness 12-60 hours. 3) No bacterial pathogen in a stool culture. There was no indication how the facility determined its qualifiers for potential outbreak based of standards of practice or quality. Review of the 12/2/24, Infection Prevention and Control Program Policy identified the program was to work to prevent, identify, investigate, and report in the attempt to control infections and communicable diseases for residents, staff, and visitors in a facility. The program was to follow the nationally accepted standards, and guidelines for infection control. The program was to include an acceptable system to monitor and document infection control and prevention. The program was to be reviewed annually by the IP or designee, to ensure compliance. The IP utilizes surveillance date to identify outcomes, trends and patterns with results communicated to the QAPI committee.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program	F 881		2/3/25

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F 881	Continued From page 32 that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an antibiotic stewardship program which included development of protocols and a system to monitor antibiotic use, to ensure appropriate antibiotics were utilized to prevent antibiotic resistance. This deficient practice had the potential to affect all 29 residents who resided in the facility. Findings include: Review of the September 2024, October 2024, and November 2024 infection control (IC) antibiotic stewardship identified the following information: Resident name, Medication prescribed, Classification of the drug, start date, end date, ordered days of therapy, actual days of therapy, Route, and abbreviation for infection without a legend to identify the infection abbreviations. The data for each report showed in: 1.) September 2024, 14 antibiotic orders with 231 days of therapy were included on the monthly IC report. Nine residents were identified as having received antibiotic therapy (R3, R5, R11, R17, R19, R24, R31, R182 and R183). 2.) October 2024, 10 antibiotic orders with 100 days of therapy. R31 was identified as receiving an ongoing oral antibiotic, but there was no identified rational, or documentation of a physician contact to identify and document the need for continued use. Three residents (R2, R8 and R11) were identified as on antibiotics for a urinary tract infection (UTI). 3.) November 2024, 16 antibiotic orders with 75	F 881	1. The residents affected was 1 of 1 resident. The prophylactic antibiotic was discontinued immediately on 1/8/25. 2. All of the residents have the potential to be affected by this deficient practice. We have reviewed all the residents charts for any antibiotic use and they were reviewed with the provider and that they have an appropriate rationale for the antibiotic use. No other resident s were found to have the order for a prophylactic antibiotic. 3. To ensure systemic changes are sustained, we have trained all the staff in the nursing department in the reasons and new process improvements for the use of antibiotics at the facility. We have reviewed our current practice and improved the process to include the following elements: We will continue to meet monthly with the antibiotic stewardship team and review all residents who are currently ordered to have antibiotic medications. The team will review the monthly infection control report and review the identified rational and the provider is contacted and communicated to for the antibiotic use. The team will ensure that the correct	

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F 881	Continued From page 33 days of therapy were documented. R7 was admitted with physician orders for an antibiotic for a prophylactic antibiotic due to a history of UTIs. The record failed to identify any consult with the physician related to Antibiotic Stewardship, the continued need for the antibiotic, and any rational or investigation as to when it had been initiated, a stop date, or follow up testing indicated. R6, R7, R13, R15, R18, R23, R24, R27, R187, R188, and R189 also received antibiotic treatment in November 2024. There was no documentation of symptoms, a time out completed, or culture/sensitivity results with notification of the physician to identify if the appropriate medication was in use or should be changed or discontinued. There was also no indication staff had re-assessed the resident's following completion of therapy or notified their physicians to identify if symptoms had resolved or if there was a need to change the medication or continue medication for a specific period. Interview on 1/8/25 at 1:25 p.m. interview with Physician (MD)-A reported he was not certain when R7 had started taking an antibiotic for a diagnosis of recurrent UTI's. Upon review of his clinical record, he identified the original order was in October of 2023. He had not investigated the use of the antibiotic at the time of admission, nor was he aware of R7 having any symptoms of a urinary tract infection since she had been admitted to the facility. He further commented he did not recall being asked about continued need for the antibiotic and reported he was not aware of any investigation or referrals to urology or infectious disease related to the need for continued use of the antibiotic. MD-A stated he felt continued use of an antibiotic for an extended	F 881	documentation is done by the nursing team correctly and in a timely manner. The nursing staff were trained in the requirements for the documentation of symptoms and that a time out is completed. As well as the culture/sensitivity result with a notification to the providers to identify the appropriate next steps. They also were educated on the need to reassess the resident s following completion of therapy and updated the provider of the assessment findings. The Antibiotic Stewardship team will report to the QAPI team monthly. We have communicated to the providers the updated process and our improved plan. We have included the updated plan in our QAPI meetings monthly. 4. To ensure compliance is maintained, daily audits of the use of antibiotics and the documentation on the affected residents will be done daily for 2 weeks, and 100% compliance is achieved. Then audits will be done twice a week for 2 weeks and 100% compliance is achieved. Then we will move to monthly audits and 100% compliance for 6 months. All findings on the audits will be reported out to the QAPI team monthly. 5. 2/3/25	

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F 881	Continued From page 34 period should be investigated further and there should be an end date to assess the need for continuation of a medication. MD-A also voiced agreement this was an area the IP should be aware of and questioning the MD for rational for the need of continued use or if the medication was effective Interview and document review on 1/8/24 at 2:30 p.m., with the IP reported she had not performed timeouts or tracked the antibiotic use through to resolution to identify if the antibiotic was appropriate, or the need to alter or change therapy was identified. The IP stated she had been on vacation and had not completed the December tracing information at the time of survey and agreed she had not performed appropriate antibiotic stewardship. There was no mention of any staff member covering the IP duties while she was away from the facility. Interview on 1/9/25 at 9:43 a.m., with the director of nursing (DON), identified she would expect a thorough IC program to include appropriate antibiotic stewardship. She was unaware no one was assigned to monitor the program when the IP had been on vacation. . Interview on 1/9/25 at 9:50 a.m., with the administrator identified she agreed antibiotic stewardship was lacking appropriate oversight. The IP had been on vacation and had failed to identify anyone designated to cover infection control surveillance while they were on vacation. Review of the 12/19/24 Antibiotic Stewardship-Rehab/Skilled policy identified staff were to follow Loeb's criteria for initiating antibiotics (which, when met, indicate that the	F 881		

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F 881	Continued From page 35 resident likely has an infection and that an antibiotic might be indicated, even if the infection has not been confirmed by diagnostic testing).	F 881		
F 882 SS=E	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 infection preventionist (IP) had appropriate training and oversight of the infection control (IC) program to management by performing current, daily cumulative infection control surveillance activities, maintain documentation of incidents, findings, and any corrective actions required, and ensure the IC program continued in her absence. Findings include:	F 882	1. All the residents had the potent to be impacted by this deficient practice. 2. All the residents had the potent to be impacted by this deficient practice. 3. To ensure systemic change are sustained, we have improved the collection of illnesses and symptoms in both the employees and resident's. We have improved the process of	2/10/25

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F 882	Continued From page 36 Refer to F880 and F881 Review of the September through December 2024 logs identified infection surveillance had not been tracked through to resolution, no tracking or trending had occurred, and December 2024 had not been performed. Interview on 1/8/25, at 2:10 p.m. with the IP identified she tracked staff illness with an illness/absence report, which was completed when a staff member called in due to illness of themselves or a child. The process was for the charge nurse to complete the form and provide a copy to the IP, director of nursing (DON), and office manager who completed the schedule. The IP reported she collected the forms and completed a report at the end of each month that was presented to the Quality Assurance (QA) committee. The IP reported she recalled R23 also being tested for Norovirus, but she had not included her on the log, and no initial clinical monitoring documentation had been completed. She stated she did not have an explanation for why this did not occur, but it was not on her log. The IP reported she had not been including documentation on surveillance or resolution of infections and when a resident had been admitted with orders for a prophylactic antibiotic she had not investigated or questioned the order. She identified completion of the IP training and provided a copy of her certificate, but stated she would like to receive additional education on how and what she needed to investigate and document, in addition to finding a format that included the necessary information. The reporting of infections and/or antibiotic use was received electronically "if staff completed the	F 882	handling, communicating and tracking the illnesses in both population groups. We have identified that the Director of Nursing will be designated to cover infection control and surveillance in the case the Infection Preventionist is out of the facility for any length of time for personal time off or illness. We have the DNS currently taking the infection prevention courses to obtain her IP certificate. The Infection Preventionist will be responsible for communicating to the Director of Nursing on any dates that she will not be in the facility to cover the duties of infection control and surveillance. The Director of Nursing will then assume responsibility for the infection control and surveillance of the facility until the Infection Preventionist returns to the facility. 4. To ensure compliance is maintained, daily audits of the Infection control and surveillance will be done daily for 2 weeks, and 100% compliance is achieved. Then audits will be done twice a week for 2 weeks and 100% compliance is achieved. Then we will move to monthly audits and 100% compliance for 6 months. All audit findings will be reported at the monthly QAPI meeting. 5. 2/10/25	

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F 882	Continued From page 37 documentation correctly". She also stated she was told by staff, or a note was left for her, for antibiotic use which she recorded on her log form. She made no follow-up to identify antibiotic stewardship had occurred, including antibiotic timeouts. The IP was unaware of the need to report potential Norovirus outbreak and had not correlated GI illness or put measures in place to prevent potential spread and ensured staff remained off work until 72 hours after symptoms subsided. Interview on 1/9/25 at 9:43 a.m., with the DON reported her expectation for the IP to correlate potential outbreak concerns related to staff and resident illness and investigate root cause with potential intervention. The DON identified there was a checklist that was supposed to be completed and sent to the IP and DON and she expected the IP to follow the facility policy and procedures about IC surveillance and documentation. She confirmed antibiotics should not be started until a culture was received and 48 hours after an antibiotic was started a time out was implemented with a form completed and sent to provider. She reported the physician was to review the appropriateness of the antibiotic and make the determination if it should continue or be changed. She confirmed R7 had been admitted on a prophylactic antibiotic and there was no documentation to indicate there had been an attempt to investigate need for continued use, or an attempt to implement alternate treatments. Interview on 1/9/25 at 9:50 a.m., with the administrator reported she was not aware of a possible correlation between the resident who was hospitalized with Norovirus and reported staff	F 882		

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F 882	Continued From page 38 illness with the same symptoms. She reported she would expect staff or family illness to be investigated and staff is not allowed to return to work until the appropriate time follow resolution of symptoms. She stated she would expect documentation to be maintained to confirm this had taken place. She reported the IP had been on vacation and failed to identify anyone designated to cover infection control surveillance while the IP was on vacation. Review of the December 2, 2024, Infection Prevention and Control Program Policy identified the program was to work to prevent, identify, investigate, and report in the attempt to control infections and communicable diseases for residents, staff, and visitors in a facility. The program was to follow the nationally accepted standards, and guidelines for infection control. The program was to include an acceptable system to monitor and document infection control and prevention. The program was to be reviewed annually by the IP or designee, to ensure compliance. The IP utilizes surveillance date to identify outcomes, trends and patterns with results communicated to the QAPI committee.	F 882		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/07/2025. At the time of this survey, Good Samaritan Society-Westbrook was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/12/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building 01 of Good Samaritan Society Westbrook was constructed as follows: The original building was built in 1961, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction; The first addition was built in 1969, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction; The second addition was built in 2001, is	K 000		

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K 000	Continued From page 2 one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction Building 03 of Good Samaritan Society Westbrook includes a 2007 building addition, consisting of a new main entrance, lobby and offices. In 2011, the dietary department was fully remodeled. These additions are one-story, have no basement, are fully sprinklered and were determined to be of Type V(111) construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a capacity of 32 beds and had a census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		1/10/25

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K 353	Continued From page 3 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 13, Standard for the Installation of Sprinkler Systems, section 8.5.6, These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 01/07/2025 between 10:00 AM an 12:30 PM, it was revealed by observation that there was storage exceeding 18 inches in the supply room located in wing 200, clean linen room in in 300 wing and in the walk in freezer, not allowing sprinkler to perform properly if activated. An interview with Administrator verified these deficient findings at the time of discovery.	K 353	1. All items were immediately removed from the identified areas. All storage areas now are free if items for the required 18 inches from the sprinkler. Signs were placed in every storage room to not place anything above the measured 18 inches by the sprinklers. 2. All residents have the potential to be affected by the deficient practice. 3. To ensure that systemic change are sustained, all staff have been educated on the Fire Prevention and Sprinkler policies and procedures. Signs have been placed to educate all staff of the actual 18 inches distance from the sprinkler. They also show the line in which items can not be placed above to meet the distance requirement. 4. To ensure compliance is maintained, daily audits of the storage area will be completed for 2 weeks and 100% compliance is achieved. Then audits will be completed twice a week for 2 weeks and 100% compliance is achieved. We will then move to monthly audits and 100% compliance is achieved for 6 months.	

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	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/07/2025**

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K 353	Continued From page 4	K 353	The Maintenance Manager will report their audit results monthly at the QAPI meetings. 5. 1/10/25	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 01/07/2025 between 10:00 AM and 12:30 PM, it was revealed by observation that there were unsealed penetrations in the smoke barrier located in the 300 wing. An interview with the Administrator verified this	K 372	1. The identified area that needed to have red fire sealant applied has been completed. 2. All the residents had the potential to be affected by this deficient practice. 3. To ensure that systemic changes are sustained, the maintenance department has placed the smoke barriers on their monthly checklist. All staff have been educated on the Fire Prevention and Smoke Barriers policy and plan.	2/10/25

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K 372	Continued From page 5 deficient finding at the time of discovery.	K 372	4. To ensure compliance is maintained, daily audits of the smoke barriers will be completed daily for 2 weeks, and 100% compliance is achieved. Then audits will be completed twice a week for 2 weeks and 100% compliance is achieved. Then monthly audits and 100% compliance is achieved for 6 months. All audit findings will be reported at the monthly QAPI meetings. 5. 2/10/25	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.6. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 712	1. The missing information was located on the fire drill forms and the corrected information was attached to the form. 2. The deficient practice had the potential to affect all the residents. 3.	2/3/25

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K 712	Continued From page 6 1. On 01/07/2025 between 10:00 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing a time for the fire drill on the first shift in the 4th quarter. 2. On 01/07/2025 between 10:00 AM and 12:30 PM it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing they pulled the alarm for the night shift frill in quarter 1, 2, and 3. An interview with the Administrator verified these deficient findings at the time of discovery.	K 712	To ensure systemic change is sustained, fire drill documentation will be reviewed monthly going forward to ensure that we have all the required information completed. All staff were trained on the Fire Prevention Policy and Plans. 4. To ensure compliance is maintained, monthly fire drills forms will be audited every month for 3 months and 100% compliance is achieved. All fire drill information will be reported and reviewed at the monthly QAPI meetings. 5. 2/3/25	
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Electrical Systems per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 911	1. The electrician was contacted and the key and lock replacements were ordered. The electrical boxes were secured until the replacements locks are installed. 2. All residents have the potential to be affected by this deficient practice.	2/10/25

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K 911	Continued From page 7 On 01/07/2025 between 10:00 AM and 12:30 PM, it was revealed that the electrical panels located in the hallway in the 100 wing were not secured from being opened by unauthorized personnel. An interview with the Administrator verified this deficient finding at the time of discovery.	K 911	3. To ensure that systemic changes are sustained, the electrical boxes in all the units are added to the monthly checks for the maintenance department to ensure they are locked and secured. All staff have been educated on the importance of having electrical systems secured. 4. To ensure compliance is maintained, audits will be completed 2 times a week for 2 weeks and 100% compliance is achieved. Then twice a week for 2 weeks and 100% compliance is achieved. Then monthly for 3 months and 100% compliance is achieved. 5. 2/10/25	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923		2/10/25

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K 923	Continued From page 8 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/07/2025 between 10:00 AM and 12:30 PM, it was revealed by observation that the Med Gas (O2) Storage Room contained storage of combustible materials. An interview with the Administrator verified this deficient finding at the time of discovery.	K 923	1. The oxygen tanks and supplies we relocated to another storage room where they are in a dedicated space for only oxygen items. 2. The deficient practice had the potential to affect all the residents. 3. To ensure systemic changes are sustained, the storage room for the oxygen and oxygen supplies have been relocated to a space that is secure and dedicated for just those items. All staff have been educated on the oxygen room relocation and on oxygen safety and policy.	

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K 923	Continued From page 9	K 923	4. To ensure compliance is maintained, daily audits will be completed for 2 times a week for 2 weeks and 100% compliance is achieved. Then 1 a week for 2 weeks and 100% compliance is achieved. Then 1 a month for 3 months and 100% compliance is achieved. All audit findings will be reported monthly at the QAPI meetings. 5. 2/10/25	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 12, 2025

Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, MN 56183

RE: CCN: 245595
Cycle Start Date: January 9, 2025

Dear Administrator:

On March 5, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112