



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2024

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

RE: CCN: 245234
Cycle Start Date: August 15, 2024

Dear Administrator:

On August 15, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by November 15, 2024 (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 February 15, 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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Good Samaritan Society - Waconia And Westview Acre

August 20, 2024

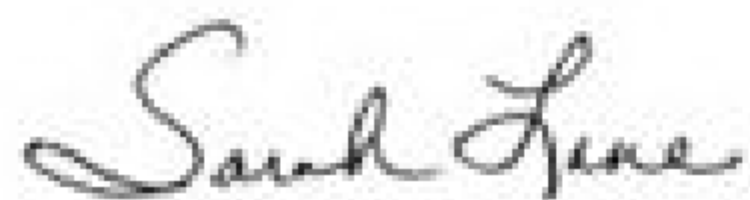
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Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

Re: State Nursing Home Licensing Orders
Event ID: EPC711

Dear Administrator:

The above facility was surveyed on August 12, 2024 through August 15, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

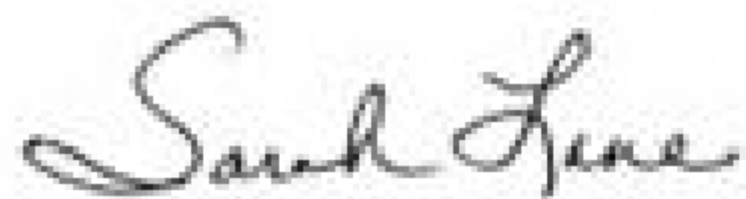
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/12/24 - 8/15/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584			9/9/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/30/2024

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

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F 584	Continued From page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain wheelchairs in a clean and sanitary manner for 2 of 2 residents (R20 and R15) reviewed for safe, clean, comfortable, and home-like environment and for 1 of 1 resident (R31) reviewed who had enteral feeding liquid spilled on the tube feeding (TF) pump and support legs of the pole. Findings include: R20's facesheet printed on 8/15/24, included			F 584	F584-Save/Clean/Comfortable/ Homelike Environment The facility failed to maintain wheelchairs in a clean and sanitary manner for residents (R20 and R15) reviewed for safe, clean, comfortable, and homelike environment and for resident (R31) reviewed who had enteral feeding liquid spilled on the tube feeding (TF) pump and support legs of the pole. 1. The wheelchairs for residents R20 and R15 have been cleaned. The TF for		

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F 584	Continued From page 2 diagnoses of cerebral hemorrhage (a type of stroke that causes bleeding in the brain), Parkinsonism (movements associated with Parkinson's disease such as stiffness and tremor) and arthritis. R20's quarterly Minimum Data Set (MDS) assessment dated 6/18/24, indicated R20 was cognitively intact, had clear speech, could understand and be understood. R20 required substantial assistance with most activities of daily living (ADL), except eating in which she was independent with set-up help. R20 did not walk and utilized a manual wheelchair. R20's care plan, printed 8/15/24, did not address cleanliness of, or cleaning her wheelchair. During an observation and interview on 8/12/24 at 2:11 p.m., R20 was in her room in her wheelchair eating lunch at a card table. Observed was on her shirt, pants and floor around her wheelchair with spilled food. R20's wheelchair was observed to be soiled with what appeared to be food debris. The stainless steel part of the arm rest was smeared with a light colored material. Crevices of the wheelchair were caked with a pale orange colored material. R20 was unaware of this and stated she didn't know if anyone cleaned her wheelchair. During an observation and interview on 8/13/24 at 4:09 p.m., with registered nurse (RN)-A, who was also a nurse manager, R20's wheelchair was observed with RN-A. RN-A stated the condition of the wheelchair was unacceptable, and stated wheelchair cleaning was on a schedule where all wheelchairs were cleaned on a regular basis.	F 584	resident R31 has been cleaned. 2. All residents in the facility have the potential to be affected by this deficient practice. All residents' wheelchairs have been inspected, cleaned and put on a weekly cleaning rotation schedule. 3. To ensure systemic changes are sustained, the Nursing staff have been educated on the on the facilities policy for cleaning wheelchairs and TF pump and support legs by the DNS/Designee. 4. The DNS/Designee will audit seven wheelchairs and three TF pump and support legs cleanings a week for four weeks for compliance. Any non-compliance will be addressed to staff in a timely manner. The findings of the audits will be reported to the Monthly QAPI for review and changes made where necessary. 5. Compliance date is 9/9/2024		

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F 584	Continued From page 3 During an interview on 8/14/24 at 9:34 a.m., the director of nursing (DON) stated she recently developed a checklist for the night shift nursing assistants (NA) to check and clean wheelchairs. The checklist was presented to staff at an all-staff meeting on 7/26/24. The expectation was for NA's to go according to the checklist and clean wheelchairs for blocks of residents each day. During the meeting, the DON showed nursing staff the location of the wheelchair washer and how to operate it. During an interview on 8/14/24 at 10:40 a.m., the DON presented a document titled "NAR (nursing assistant registered) NOC (night) CHECKLIST," which identified the schedule for washing resident wheelchairs. The checklist indicated R20's wheelchair would be washed every Monday. The DON stated she would have expected R20's wheelchair to have been washed on Monday 8/12/24. The DON was informed of the amount of food debris stuck deep into crevices of the wheelchair and had not likely been cleaned for some time. R15's facesheet printed on 8/15/24, included diagnoses of ataxia (impaired coordination). R15's quarterly MDS dated 5/30/24, indicated R15 was cognitively intact, had clear speech, could understand and be understood. R15 required substantial assistance for most ADL's. R15 did not walk and used a motorized wheelchair. R20's care plan, printed on 8/15/24, did not address cleanliness of, or cleaning her wheelchair.	F 584			

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F 584	Continued From page 4 During an observation and interview on 8/15/24 at 9:47 a.m., in the exercise room for restorative nursing, R15 was observed exercising on a recumbent bike. R15's motorized wheelchair was parked next to her. On observation the foot rest appeared to have rust and debris around perimeters of the foot rest. In addition, the vinyl on both arm rests appeared to have been torn and were secured with tape. (NA)-B, stated R15 went all over with her wheelchair, including locations outside of the facility. NA-B stated since the wheelchair was motorized, it could not go through the wheelchair washer. R15 who had been at the facility less than a year did not recall it having been cleaned and stated it would be nice if it could be cleaned. During an interview on 8/15/24 at 11:46 a.m., the DON was shown photos of R15's wheelchair. The DON stated the chair belonged to R15 and since it was motorized, could not be put in the wheelchair washer, however, expected staff to notice it and clean it and/or report the condition of armrests to someone. During an interview on 8/15/24 at 2:29 p.m., NA-A was not aware of cleanliness of R15's wheelchair, but was aware of the tape on armrests and stated she did not think to bring that to anyone's attention, adding she thought if it was R15's wheelchair, R15 wanted it that way. A facility policy for maintenance of resident equipment was requested and not received. R31's quarterly Minimum Data Set, dated 7/15/24, included R31 was cognitively intact and dependent on staff for most activities of daily			F 584			

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F 584	Continued From page 5 living with diagnoses of a stroke, malnutrition, and hemiparesis (weakness or inability to move on one side of the body). R31's medical administration record (MAR) and treatment administration records (TAR) for August 2024, indicated R33 received "Isosource 1.5 120 cc x 5 hours via G-tube daily one time a day 600ml total, start at 8 PM, remove at 1:00 AM or after 5 hours, Ok for Jevity 1.5 to replace Isosource 1.5. and remove per schedule." There were no orders regarding cleaning of the TF pump or pole. During observation on 8/12/24 at 2:36 p.m., R31 was lying in bed in their room with TFs not running. The TF pump was attached to a pole with four support legs to the right of the bed. On all the legs, there was a dried brown and tan substance which covered more than 50% on all the legs, the TF pump itself had similar streaks, and several splotches greater than 2-inches on the floor underneath the pole. During interview on 8/12/24 at 2:36 p.m., R31 stated the facility had not cleaned it and that it should be cleaned. During observation and interview on 8/13/24 at 1:48 p.m., the dried brown and tan substance was still present on the pump, pole, and floor. R31 expressed disappointment in the lack of cleanliness. During interview on 8/13/24 at 2:03 p.m., nursing assistant (NA)-A stated not knowing who was responsible for cleaning the pole and pump. NA-A verified the condition of the pole, pump, and floor and described it as "gross."			F 584			

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F 584	Continued From page 6 During interview on 8/13/24 at 2:49 p.m., housekeeping-A stated to their knowledge the cleaning of TF pumps and poles was not their responsibility. During interview on 8/13/24 at 2:51 p.m., licensed practical nurse (LPN)-A verified the dirty condition of the pole, pump, and floor and stated that it should be cleaned. LPN did not provide an answer on who was responsible for cleaning this equipment. During interview on 8/14/24 at 11:31 a.m., the director of nursing (DON) stated they were not sure whose responsibility it was but would have expected staff to clean if dirty. Cleaning policy regarding TF pump and pole requested, none provided.	F 584			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609			9/9/24

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
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F 609	Continued From page 7 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the administrative staff and State Agency (SA) were notified immediately but no later than 2 hours of an allegation of abuse for 1 of 1 residents (R5) who reported "abusive" cares during toileting cares provided by staff. Findings include: R5's quarterly Minimum Data Set (MDS) dated 6/13/24, indicated R5 did not present any inattention, disorganized thinking, or altered level of consciousness. The MDS indicated R5 had moderately impaired cognitive skills for decision making regarding tasks of daily life and there were short- and long-term memory problems, according to staff interview. The MDS also indicated R5 required substantial to maximal assistance from a staff helper with toileting hygiene and could be independent with personal hygiene. The MDS listed diagnoses of hemiplegia (paralysis on one side of the body) of the left side, high blood pressure, dementia (the loss of cognitive function, like thinking, remembering,	F 609	F609- Reporting Alleged Violations. The facility failed to ensure the administrative staff and State Agency (SA) were notified immediately but no later than 2 hours of an allegation of abuse involving resident R5. 1. Resident R5 has been interviewed by SSD/Designee to ensure she/he feels safe. 2. All residents in the facility have the potential to be affected by this deficient practice. There have been no further allegations of abuse since this incident. 3. To ensure systemic changes are sustained, all staff have been educated on the reporting requirements for Abuse and Neglect Allegations reporting by the DNS/Designee. Newly hired staff receive Abuse and Neglect training during General Orientation (GO) and annually after that.		

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F 609	Continued From page 8 and reasoning), anxiety, depression, bipolar disorder, schizophrenia (mental health disorder that can affect a person's ability to think, feel, and behave), and insomnia (a sleep disorder). R5's care plan dated 1/23/13, indicated she had an activity of daily living (ADL) self-care performance deficit related to her left hemiplegia as evidenced by her inability to complete ADLs independently. The care plan identified interventions including staff assistance with toileting cares and a preference for no male caregivers. R5's care plan dated 10/9/23, indicated she had a mood problem related to her diagnoses as evidenced by a history of unrealistic fears and plans, becoming easily upset with others, being resistive with cares, and rude comments/talking about staff and other residents. The interventions identified in the care plan indicated staff would redirect R5 and notify the nurse and/or social services if R5 was making rude comments towards staff or other residents. R5's care plan was reviewed on 8/14/24 and lacked indications of her vulnerable adult status and interventions to overcome the potential for abuse. A progress note dated 5/25/24, indicated an unidentified nursing assistant (NA) reported during evening toileting cares while cleaning R5's perineal area, she, "complained that aide was 'abusing' resident by cleaning resident's bottom after toileting." A review of R5's electronic health record (EHR) on 8/14/24 revealed a lack of documentation of	F 609	4. The DNS/Designee will interview 5 staff weekly for 4 weeks to validate their understanding of the Abuse and Neglect Allegations reporting process. Re-education will be given to those who need a refresher. The DNS/Designee will review the daily nursing documentation daily in the morning meeting for potential allegations of abuse. The findings of the audits will be reported to the Monthly QAPI for review and changes made where necessary. 5. Compliance date is 9/9/2024		

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F 609	Continued From page 9 an incident report or investigation of R5's allegation of abuse on 5/25/24. Aspen Complaint/Incidents Tracking System (ACTS) was reviewed on 8/14/24, and revealed no reported complaints or incidences for R5's allegation of abuse on 5/25/24. A request was made on 8/15/24 for incident reports, investigation reports, and/or risk management reports for R5 pertaining to the allegation of abuse dated 5/25/24 were requested but not received. During interview on 8/15/24 at 11:50 a.m., R5 stated she felt safe in the facility. R5 was unable to recall the allegation of abuse. During interview on 8/15/24 at 9:39 a.m., registered nurse (RN)-B confirmed being familiar with R5's care and verified progress note documentation dated 5/25/24. RN-B stated the NA assisted R5 with toileting and performed incontinence cares, then reported the comments R5 made about "abusing" her after cares. RN-B stated R5 had behaviors of berating or insulting staff she didn't like and refusing cares or refusing to be changed after incontinence. RN-B stated effective interventions included re-approach, finding different staff to attempt the cares, or finding R5's preferred staff to perform the cares. RN-B stated the nurse manager was notified by e-mail of the allegation and could not recall any follow-up. RN-B stated there was annual computer-based abuse training required by the facility. RN-B stated the timeline for reporting a suspected abuse allegation was "immediately" and could not think of a situation in which an allegation of abuse would not be reported.	F 609			

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F 609	Continued From page 10 During interview on 8/15/24 at 4:16 p.m., social services (SS)-A stated staff were expected to call the manager on-duty if something happened during off-hours and they were questioning if it was reportable. SS-A stated it would not be acceptable to disregard an allegation of abuse because a resident's care plan indicated the resident had similar behaviors and the expectation was to follow the procedure. During interview on 8/15/24 at 10:44 a.m., the director of nursing (DON) verified the progress note dated 5/25/24 and acknowledged first becoming aware of the allegation of abuse during a discussion at the following Monday, 5/27/24, morning's interdisciplinary team (IDT) meeting. The DON stated staff familiar with R5 determined it was a behavior and was her "M.O." During subsequent interview on 8/15/24 at 3:50 p.m., the DON stated staff were expected notify the DON immediately if there were allegations of abuse. The DON stated it was important because the investigation process could begin immediately, "we can re-interview people, re-assess the situation to see what is going on and if we need to do more." The DON stated the risk of not reporting an allegation of abuse immediately but no later than 2 hours was there could be "someone working in the building that shouldn't be." During interview on 8/15/24 at 2:54 p.m., the administrator stated staff were expected to follow the guidelines for abuse reporting. The administrator stated it was not staff's responsibility to determine what was a valid allegation and stated, "an allegation is an	F 609			

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F 609	Continued From page 11 allegation." The administrator verified the two-hour timeline for abuse reporting and stated any allegation was expected to be reported as soon as possible so the facility could initiate an investigation. A facility policy titled Abuse and Neglect-Rehab/Skilled, Therapy & Rehab dated 7/22/24, indicated the purpose was to ensure residents are not subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants r volunteers, employees of other agencies servicing the individual, family members, or legal guardians, friends or other individuals. Furthermore, the policy indicated its purpose was to ensure all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly report and investigated. The policy stated the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy indicated alleged or suspected violations involving mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator, or in the administrator's absence, the director of nursing or supervisor of social services.	F 609			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610			9/9/24

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F 610	Continued From page 12 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate allegations of abuse and implement appropriate interventions for 1 of 1 residents (R5) reviewed for abuse allegations. Findings include: R5's quarterly Minimum Data Set (MDS) dated 6/13/24, indicated R5 did not present any inattention, disorganized thinking, or altered level of consciousness. The MDS indicated R5 had moderately impaired cognitive skills for decision making regarding tasks of daily life and there were short and long-term memory problems, according to staff interview. The MDS also indicated R5 required substantial to maximal assistance from a staff helper with toileting hygiene and could be independent with personal hygiene. The MDS listed diagnoses of hemiplegia (paralysis on one side of the body) of the left side, high blood pressure, dementia (the loss of cognitive function, like thinking, remembering, and reasoning), anxiety, depression, bipolar disorder, schizophrenia (mental health disorder that can affect a person's ability to think, feel, and			F 610	F610-Investigate/Prevent/Correct Alleged Violation The facility failed to thoroughly investigate allegations of abuse and implement appropriate interventions for resident R5 reviewed for abuse allegations. 1. Resident R5 has been interviewed by SSD/Designee to ensure she/he feels safe. 2. All residents in the facility have the potential to be affected by this deficient practice. There have been no further allegations of abuse since this incident. 3. To ensure the systemic changes are sustained, the administrative staff have been educated on the requirements for investigating allegations of abuse and implementing appropriate interventions by the Administrator/Designee. 4. The Administrator/Designee will audit any newly reported allegations of abuse for compliance with those requirements for investigation, and implementation of		

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F 610	Continued From page 13 behave), and insomnia (a sleep disorder). R5's care plan dated 1/23/13, indicated she had an activities of daily living (ADL) self-care performance deficit related to her left hemiplegia as evidenced by her inability to complete ADLs independently. The care plan identified interventions including staff assistance with toileting cares and a preference for no male caregivers. R5's care plan dated 10/9/23, indicated she had a mood problem related to her diagnoses and was evidenced by history of unrealistic fears and plans, becoming easily upset with others, being resistive with cares, and rude comments/talking about staff and other residents. The interventions identified in the care plan indicated staff would redirect R5's and notify the nurse and/or social services if R5 was making rude comments towards staff or other residents. R5's care plan was reviewed on 8/14/24 and lacked indications of her vulnerable adult status and interventions to overcome the potential for abuse. A progress note dated 5/25/24, indicated an unidentified nursing assistant (NA) reported during evening toileting cares while wiping R5's perineal area, R5, "complained that aide was 'abusing' resident by cleaning resident's bottom after toileting." A review of R5's electronic health record (EHR) on 8/14/24 revealed a lack of documentation of an incident report or investigation of R5's allegation of abuse on 5/25/24.	F 610	interventions during the morning meeting. The findings of the audits will be reported to the Monthly QAPI for review and changes made where necessary. 5. The Compliance date is 9/9/2024.		

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F 610	Continued From page 14 The Aspen Complaint/Incidents Tracking System (ACTS) was reviewed on 8/14/24, and revealed no reported complaints or incidences for R5's allegation of abuse on 5/25/24. A request was made on 8/15/24 for incident reports, investigation reports, and/or risk management reports for R5 pertaining to the allegation of abuse dated 5/25/24 were requested but not received. During interview on 8/15/24 at 11:50 a.m., R5 stated she felt safe in the facility. R5 was unable to recall the allegation of abuse. During interview on 8/15/24 at 9:39 a.m., registered nurse (RN)-B confirmed being familiar with R5's care and verified progress note documentation dated 5/25/24. RN-B stated the NA performed perineal and incontinence cares for R5, then reported the comments R5 made about abuse during the cares. RN-B stated R5 had behaviors of berating or insulting staff she didn't like and refusing cares or refusing to be changed after incontinence. RN-B stated effective interventions included re-approach, finding different staff to attempt the cares, or finding R5's preferred staff to perform the cares. RN-B stated the nurse manager was notified by e-mail of the allegation and could not recall any follow-up. RN-B stated there was annual computer-based abuse training required by the facility. RN-B stated the timeline for reporting a suspected abuse allegation was "immediately" and could not think of a situation in which an allegation of abuse would not be reported. During interview on 8/15/24 at 4:16 p.m., social services (SS)-A stated staff were expected to call	F 610			

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F 610	Continued From page 15 the manager on-duty if something happened during off-hours and they were questioning if it was reportable. SS-A stated it would not be acceptable to disregard an allegation of abuse because a resident's care plan indicated the resident had similar behaviors and the expectation was to follow the procedure. SS-A verbalized a wish for further follow-up on R5's allegation of abuse. SS-A stated the normal process after reporting an allegation of abuse would be to discuss the situation with the DON and administrator, interview the resident involved and other residents, interview involved staff, get the details of the situation to determine as an IDT if the event should be reported. SS-A stated during a recent skills fair, staff were educated on calling management if they were questioning if an event was reportable "so we can talk it out and determine it together." During interview on 8/15/24 at 10:44 a.m., the director of nursing (DON) verified the progress note dated 5/25/24 and acknowledged first becoming aware of the allegation of abuse during a discussion at the following Monday, 5/27/24, morning's interdisciplinary team (IDT) meeting. The DON stated staff familiar with R5 determined it was a behavior and it was her "M.O." The DON was not aware of interviews or an investigation being completed with R5 or the NA who provided cares, nor was the DON aware of any investigation performed about the alleged abuse. During subsequent interview on 8/15/24 at 3:50 p.m., the DON stated staff were expected notify the DON immediately if there were allegations of abuse. The DON stated it was important because the investigation process could begin immediately, "we can re-interview people,	F 610			

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F 610	Continued From page 16 re-assess the situation to see what is going on and if we need to do more." During interview on 8/15/24 at 2:54 p.m., the administrator stated staff were expected to follow the guidelines for abuse. The administrator stated it was not staff's responsibility to determine what was a valid allegation and what was not and stated, "an allegation is an allegation." The administrator verified the two-hour timeline for abuse reporting but stated any allegation was expected to be reported as soon as possible so the facility could initiate an investigation. The administrator stated the investigation process before reporting an allegation would include re-interviewing the resident, assessing a resident's cognition, reviewing the care plan, and reviewing past reports for any history of past allegations. The administrator stated the information was used to help determine if an event was reportable within the two-hour reporting timeline. A facility policy titled Abuse and Neglect-Rehab/Skilled, Therapy & Rehab dated 7/22/24, indicated the purpose was to ensure residents are not subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants r volunteers, employees of other agencies servicing the individual, family members, or legal guardians, friends or other individuals. Furthermore, the policy indicated its purpose was to ensure all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly report and investigated. The policy stated the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy indicated	F 610			

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F 610	Continued From page 17 alleged or suspected violations involving mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator, or in the administrator's absence, the director of nursing or supervisor of social services.	F 610			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate orthostatic blood pressure monitoring was in place for 1 of 5 residents (R5) reviewed for psychotropic medications; in addition, the facility failed to implement bowel movement (BM) protocol for 1 of 4 residents (r43) reviewed for constipation. Findings include: R5's quarterly Minimum Data Set (MDS) dated 6/13/24, indicated there was no inattention, disorganized thinking, or altered level of consciousness present. The MDS indicated according to staff, R5 had moderately impaired cognitive skills for decision making regarding tasks of daily life and there were short and long-term memory problems. The MDS also	F 684	F684-Quality of Care The facility failed to ensure appropriate orthostatic blood pressure monitoring was in place for resident (R5) reviewed for psychotropic medications, in addition, the facility failed to implement bowel movement (BM) protocol for resident R43 reviewed for constipation. 1. Resident R5 has orthostatic blood pressures monthly added to his/her TAR. R43 has had his/her Care Plan updated to reflect constipation monitoring and/or management. 2. All residents in the facility have the potential to be affected by this deficient practice. All residents who are currently receiving scheduled Psychotropic		9/9/24

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F 684	Continued From page 18 indicated R5 required substantial to maximal assistance from a staff helper with toileting hygiene and could be independent with personal hygiene. The MDS listed diagnoses of hemiplegia (paralysis on one side of the body) of the left side, high blood pressure, dementia (the loss of cognitive function, like thinking, remembering, and reasoning), anxiety, depression, bipolar disorder (wide mood swings), schizophrenia (mental health disorder that can affect a person's ability to think, feel, and behave), mood disorder, and insomnia (a sleep disorder). R5's current physician orders printed 8/15/24, included the following: - "citalopram hydrobromide (for depression) tablet 40 milligrams (mg), Give 1 tablet by mouth at bedtime, [dated 1/18/17]. Antidepressant common side effects: constipation, drowsiness, dry mouth, headache, nausea, weight gain, tachycardia (rapid heart rate), irregular heart beat." - "quetiapine fumarate (for schizoaffective disorder, bipolar disorder), Give 25 mg by mouth in the morning, dated 1/15/21. Side effects: muscle spasms of the neck and back, shuffling walk, tic-like movements of the head, face and neck, trembling and shaking of the hands and fingers, blurred vision, constipation, drowsiness, dizziness, and dry mouth." - "quetiapine fumarate (for psychosis (a mental disorder characterized by a disconnection from reality), bipolar disorder), Give 37.5mg by mouth at bedtime, [dated 1/15/21]. Side effects: muscle spasms of the neck and back, shuffling walk, tic-like movements of the head, face and neck,	F 684	Medications have been audited for regular Orthostatic Blood Pressures. Residents who currently have an alert for bowel movements have been assessed for the necessity for administration of PRN medications. 3. To ensure the systemic changes are stained, the nursing staff have been educated on the facilities Psychotropic Medications policy and the Bowel and Bladder Evaluation, Assessment, Toileting Programs policy by the DNS/Designee. 4. The DNS/Designee will randomly audit 3 residents weekly for 4 weeks for compliance with orthostatic blood pressure monitoring for compliance. The DNS/Designee will monitor the daily Bowel and Bladder alerts in PCC in the morning meeting and address any non-compliance. The findings of the audits will be reported to the Monthly QAPI for review and changes made where necessary. 5. The Compliance date is 9/9/2024		

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F 684	Continued From page 19 trembling and shaking of the hands and fingers, blurred vision, constipation, drowsiness, dizziness, and dry mouth." - "Please obtain ortho (orthostatic) blood pressure one time a day every 1 month starting on the 21st for use of Seroquel [quetiapine fumarate]," dated 9/20/19. R5's treatment administration records (TAR) for June 2024 and July 2024 were reviewed for orthostatic blood pressure monitoring. The TAR entry dated 6/21/24 contained a checkmark, which indicated per the chart codes legend it was "administered". The TAR lacked documentation of the orthostatic blood pressure reading. The TAR entry dated 7/21/24 contained a checkmark indicating it was "administered" but lacked documentation of the orthostatic blood pressure reading. A review of the facility's charting software, PointClickCare (PCC), on 8/14/24, lacked documentation of orthostatic blood pressure monitoring. R5's care plan revised on 1/29/24, indicated she had a mood problem related to her mood disorder, psychosis, depression, and dysthymia (mild but long-term form of depression). The listed goal was to maintain a stable mood state with medications and approaches. Interventions included administering medications as ordered and observing for adverse consequences. During interview on 8/15/24 at 3:50 p.m., the director of nursing verified the monitoring order was in place for R5. Additionally, the DON reviewed R5's electronic health record (EHR) and			F 684			

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F 684	Continued From page 20 verified there were no documented orthostatic blood pressure readings. The DON stated the risk of not monitoring blood pressures for a resident taking psychotropic medications could be an increased risk of falls due to dizziness. A facility policy titled Psychotropic Medications-Rehab/Skilled dated 12/6/23, indicated throughout the administration of psychotropic medications, monitoring for side effects of the medication must be completed. Additionally, the policy guided staff to monitor for effectiveness and potential adverse consequences and identified tools available for such monitoring that included, but were not limited to, the Patient Health Questionnaire (PHQ-P) in PCC and the Care Area Assessments (CAA). R43's quarterly Minimum Data Set (MDS) dated 6/4/24, identified R43 required substantial to complete dependence on staff for all activities of daily living, always incontinent of bowel, receiving scheduled and as need pain medication, and no rejection of care behaviors. Diagnoses included dementia, anemia, and gastro-esophageal reflux disease (condition in which stomach acid repeatedly flows bak up into the tube connecting the mouth and stomach). Nursing assistant (NA) documentation "task: toileting" was reviewed for the following dates: 7/16/24 to 8/14/24. No BM was charted for 10 consecutive days between 7/23/24 to 8/1/24. R43's July and August 2024 medication administration records (MAR) indicated, R43 received Polyethylene Glycol (laxative) 3350 Powder 17 grams mixed with water or juice daily and three sennoside-docusate Sodium tablets	F 684			

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F 684	Continued From page 21 twice a day for constipation. R43's MARs also indicated the following medications: -Give one Bisacodyl 10 milligrams (mg) suppository rectally daily as needed for constipation and to contact provider if there were three days without a significant bowel movement (BM). -Give one Sodium Phosphates application rectally daily as needed for constipation, to contact provider if there were three days without significant BM, and to not use in residents with renal failure. -Give 30 milliliters (mL) of Milk of Magnesia Suspension by mouth daily as needed for constipation, to contact provider if there were three days without a significant BM and contraindicated for resident with renal impairment. R43's care plan printed on 8/14/24, lacked documentation regarding constipation monitoring or management. During interview on 8/14/24 at 11:50 a.m., the director of nursing (DON) stated the leadership teams met every morning, Monday through Friday, to discuss the dashboard. DON stated the dashboard displayed residents who had not had a BM by day 2. DON stated the nurse managers would then check in with the floor nurses regarding bowel planning for that day. During interview on 8/15/24 at 1:42 p.m., the infection preventionist (IP)-C confirmed the same daily discussion with the DON regarding BMs. IP-C confirmed that R43 went 10 days without a bowel movement and no as needed medications	F 684			

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F 684	Continued From page 22 were given for constipation. During interview on 8/15/24 at 2:05 p.m., licensed practical nurse (LPN)-B stated that leadership speaks with the nurses of residents who have not had a BM and would then give the as-needed medication(s). LPN-B stated if there were no orders, we may use standing orders (orders nursing staff can initiate independently). During review of standing orders dated 10/22, the as-needed medications on R43's MAR were the same as the facility standing orders. A facility policy titled Bowel & Bladder: Evaluation, Assessment, Toileting Programs - Rehab/Skilled, Therapy & Rehab dated 5/21/24, indicated possible interventions regarding constipation to include: diet, fluid intake, activity, position, abdominal massage, consistent timing, medications, and skin considerations.	F 684			
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	F 812			9/9/24

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F 812	Continued From page 23 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 ensure 3 of 4 kitchen fans were free of lint buildup and cleaned on a regular schedule. This had the potential to affect all the residents, staff, and visitors who consumed food from the main kitchen. Findings Include: During observation in the main kitchen on 8/14/24 at 9:21 a.m., fan #1 was attached near a corner of a wall, approximately 7 ½ feet off the ground, and slightly angled down. This fan moved air into the dish return and cleaning area. Fan #2 was attached near a corner of a wall, approximately 7 ½ feet off the ground, and slight angled down. This fan moved air by one refrigerator, one freezer, and into the steam tray holding area. Fan #3 was attached on a wall, approximately 7 ½ feet off the ground, and angled down. This fan blew into the kitchen prep zone which also includes the fryer, steamers, and mixer. All three fans had lint build up on the wire guard (shroud that protects the fan blades). This build up was noticeable on the front and rear portions with multiple strands of lint, approximately 1 ½ to 2 inches, attached to the guard and moving with the air flow. During interview on 8/14/24 at 9:21 a.m., kitchen manager (KM)-A verified the lint the buildup on the fans and stated that it is on their list of things	F 812	F812-Food Procurement, Store/Prepare/Serv-Sanitary The facility failed to ensure 3 of 4 kitchen fans were free of lint buildup and cleaned on a regular schedule. 1. All the fans in the Kitchen have been cleaned. 2. All residents and families in the facility have the potential to be affected by this deficient practice. 3. To ensure the systemic changes are sustained, the monthly cleaning of the kitchen fans task has been entered into the facilities TELS system to ensure cleaning is completed timely. The Dietary Manager and Maintenance Manager have been educated on the facilities policy on cleaning kitchen fans by the Administrator/Designee 4. The Administrator/Designee will monitor the facility monthly TELS task report as well as visual inspection of the fans for compliance. The findings of the audits will be reported to the Monthly QAPI for review and changes made where necessary. 5. The Compliance date is 9/9/2024		

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F 812	Continued From page 24 to take care of in the kitchen. During interview on 8/15/24/ at 12:44 p.m., the director of environmental services stated there was no set schedule for cleaning the fans. During interview on 8/15/24 at 3:51 p.m., the director of nutritional services stated, "it's been a while since the fans were cleaned" and was unable to recall the last time the fans were cleaned. A kitchen cleaning schedule was requested and identified that different areas of the kitchen were cleaned over a four week period during each month. The kitchen fans were scheduled to be cleaned during the third week of the month on Thursdays.	F 812			
F 880 SS=D	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,	F 880			9/9/24

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F 880	Continued From page 25 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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; (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.	F 880			

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F 880	Continued From page 26 §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 ensure proper infection control practice for 1 of 2 residents (R17) reviewed for urinary catheter care. In addition, the facility failed to utilize enhanced barrier precautions (EBP) for 1 of 4 residents (R33) reviewed for infection control. Findings include: R17 R17's quarterly Minimum Data Set (MDS) dated 6/7/24, identified R17 as cognitively intact, no rejection of care behaviors, dependent on most activities of daily living (ADL), and indicated an indwelling catheter. Diagnoses included neurogenic bladder (lack of bladder control due to a brain, spinal cord, or nerve problem), hyponatremia (low sodium levels), and multiple sclerosis (MS) (chronic disease of the central nervous system). R17's physician order dated 3/4/24, indicated R17 received Hiprex (antibiotic) tablet 1 gram by mouth two times a day for "urinary anti-infective." R17's care plan (CP) dated 5/16/13 indicated, the resident has an "Indwelling Catheter R/T MS,	F 880	F-880-Infection Prevention & Control The facility failed to ensure proper infection control practice for resident R17 reviewed for urinary catheter care. In addition, the facility failed to utilize enhanced barrier precautions (EBP) for resident R33 reviewed for infection control. 1. R17's Care Plan has been updated to reflect specific interventions for Cath Care. 2. All residents in the facility have the potential to be affected by this deficient practice. All residents who currently have catheters have been audited for proper infection control practices. 3. To ensure the systemic changes are sustained, nursing staff have been educated on the updated Care Plan for resident R17 by the DNS/Designee. The nursing staff have also been educated on the facilities Cath Care and Infection Control policies involving residents who have EBP precautions by the DNS/IP/Designee. 4. The IP/Designee will monitor the use of proper PPE usage on 2 residents with		

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F 880	Continued From page 27 Neurogenic Bladder. Resident will not develop infection or other complications of catheter use through review date." The interventions directed staff to monitor, record, and report to health care provider for signs and symptoms of urinary tract infections which included pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. It also indicated to clean resident's catheter every shift and report unusual observations and conditions to the nurse. During observation on 8/12/24 at 3:06 p.m., R17 was lying in bed with their urinary foley catheter tubing draped over their left leg with the catheter bag on the floor without a barrier. During observation on 8/13/24 at 2:35 p.m., R17's urinary foley catheter bag was on the floor without a barrier. During interview on 8/13/24 at 2:54 p.m., licensed practical nurse (LPN)-B stated foley catheter bags were not to be on the ground due to an infection control issue. LPN-B confirmed the bag was on the floor without a barrier. During observation and interview on 8/14/24 at 8:12 a.m., R17's catheter bag which was on the floor and half out of the dignity bag (an opaque bag). Nursing assistant (NA)-C emptied the catheter bag, placed the catheter bag inside the dignity bag, and strapped the dignity bag to the bed frame. NA-C stated the foley bag should not have been on the ground but in the dignity bag attached to the frame.	F 880	EBP precautions weekly for 4 weeks. And the IP/Designee will audit 2 residents with catheters for 4 weeks for compliance. On the spot education will be given for non-compliance. The findings of the audits will be reported to the Monthly QAPI for review and changes made where necessary. 5. The Compliance date is 9/9/2024		

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F 880	Continued From page 28 During interview on 8/14/24 at 11:32 a.m., the director of nursing (DON) stated that foley catheters should have dignity bags and that foley catheter bags should not be on the ground due to an infection control risk. During interview on 8/15/24 at 1:29 p.m., the infection preventionist (IP) stated the resident had a behavior of picking up the foley bag to weigh it and then placed it on the ground. IP stated in the past they tried different interventions to mitigate the infection risk such as multiple dignity bags or basins for the catheter bag to land in. IP was unaware that this behavior had returned. Policies regarding foley catheters requested, none provided. R33 R33's significant change in status MDS dated 5/8/24, indicated R20 required substantial assistance in all ADLs, the presence of pressure ulcers, and diagnoses which included aphasia (the loss of ability to understand or express speech) and hemiparesis (weakness or the inability to move one side of the body). R33's CP dated 8/12/14, indicated R33 having an unstageable pressure ulcer (full thickness tissue loss where the depth of the wound is completely obscured by eschar); however, the CP did not address EBP. R33's order summary report printed 8/14/24, lacked orders regarding EBP. During observation on 8/12/24 at 1:30 p.m., R33's			F 880			

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F 880	Continued From page 29 door frame had a magnetic sign indicating R33 was on EBP. During observation on 8/12/24 at 6:54 p.m., NA-E and NA-D completed hand hygiene and donned gloves but did not gown. They repositioned a mechanical lift sling located underneath R33. The mechanical lift was attached to the sling in an appropriate configuration. R33 was raised from chair and moved with mechanical lift to the bed. R33 was lowered then the sling was disconnected from the lift. The mechanical lift sling and pants were partially removed as R33 was rolled to the left where NA-D was positioned. R33 was rolled right with the mechanical lift sling and pants being fully removed. R33 was placed supine (on back) position, the Velcro on the brief was undone, perineal care was completed by NA-E. R33 was rolled to the left with NA-E completing perineal care. NA-E doffed gloves went to R33's bathroom and donned new gloves. A new brief was positioned under R33. Registered nurse (RN)-D entered the room with gloves donned and with no gown, changed the dressing on R33's coccyx wound, the wound was then cleansed with a saline soaked kerlix, patted dry with another kerlix, and a new dressing applied. RN-D doffed gloves, went in R33's bathroom, and donned new gloves and again did not gown. The dressing on the R33's right elbow was cleansed and dressed in the same manner by RN-D. R33 was placed in the supine position and Nystatin powder was applied to the groin area. NA-E and NA-D attached the Velcro on the brief. The bed height was lowered, the head of bed elevated, and call light placed. Gloves were then doffed by staff. During interview on 8/12/24 at 7:33 p.m., RN-D stated that EBP were meant for dealing with	F 880			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page 30 wounds that have an active infection like the wound on R33's right leg not regarding other wounds. NA-E and NA-D were both present and in agreement with RN-D. During interview on 8/14/24 at 11:29 a.m., DON stated that staff were to wear a gown and gloves while doing wound and perineal cares for resident's on EBP. During interview on 8/14/24 at 1:48 p.m., IP stated EBP has been rough for the facility, and it has required constant reeducation to staff on wearing personal protective equipment. A facility document titled Enhanced Barrier Precautions (EBP) Protocol undated, indicated to nursing staff "that EBP is needed in the room during high contact care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, indwelling device care/use, wound care."	F 880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/12/24 to 8/15/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure and the following correction orders are issued.	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

08/30/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2024
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2 000	Continued From page 1 Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. MDH is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000			

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 4 kitchen fans were free of lint buildup and cleaned on a regular schedule. This had the potential to affect all the residents, staff, and visitors who consumed food from the main kitchen. Findings Include: During observation in the main kitchen on 8/14/24 at 9:21 a.m., fan #1 was attached near a corner of a wall, approximately 7 ½ feet off the ground, and slightly angled down. This fan moved air into the dish return and cleaning area. Fan #2 was attached near a corner of a wall, approximately 7 ½ feet off the ground, and slight angled down. This fan moved air by one refrigerator, one freezer, and into the steam tray holding area. Fan #3 was attached on a wall, approximately 7 ½ feet off the ground, and angled down. This fan blew into the kitchen prep zone which also includes the fryer, steamers, and mixer. All three	21015	Corrected	9/9/24	

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21015	Continued From page 3 fans had lint build up on the wire guard (shroud that protects the fan blades). This build up was noticeable on the front and rear portions with multiple strands of lint, approximately 1 ½ to 2 inches, attached to the guard and moving with the air flow. During interview on 8/14/24 at 9:21 a.m., kitchen manager (KM)-A verified the lint the buildup on the fans and stated that it is on their list of things to take care of in the kitchen. During interview on 8/15/24/ at 12:44 p.m., the director of environmental services stated there was no set schedule for cleaning the fans. During interview on 8/15/24 at 3:51 p.m., the director of nutritional services stated, "it's been a while since the fans were cleaned" and was unable to recall the last time the fans were cleaned. A kitchen cleaning schedule was requested and identified that different areas of the kitchen were cleaned over a four week period during each month. The kitchen fans were scheduled to be cleaned during the third week of the month on Thursdays. SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding kitchen sanitation. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment.	21015			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND		STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387			
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21015	Continued From page 4	21015	Corrected	9/9/24	
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control practice for 1 of 2 residents (R17) reviewed for urinary catheter care. In addition, the facility failed to utilize enhanced barrier precautions (EBP) for 1 of 4 residents (R33) reviewed for infection control. Findings include: R17 R17's quarterly Minimum Data Set (MDS) dated 6/7/24, identified R17 as cognitively intact, no rejection of care behaviors, dependent on most activities of daily living (ADL), and indicated an indwelling catheter. Diagnoses included neurogenic bladder (lack of bladder control due to a brain, spinal cord, or nerve problem), hyponatremia (low sodium levels), and multiple sclerosis (MS) (chronic disease of the central nervous system).				

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21385	Continued From page 5 R17's physician order dated 3/4/24, indicated R17 received Hiprex (antibiotic) tablet 1 gram by mouth two times a day for "urinary anti-infective." R17's care plan (CP) dated 5/16/13 indicated, the resident has an "Indwelling Catheter R/T MS, Neurogenic Bladder. Resident will not develop infection or other complications of catheter use through review date." The interventions directed staff to monitor, record, and report to health care provider for signs and symptoms of urinary tract infections which included pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. It also indicated to clean resident's catheter every shift and report unusual observations and conditions to the nurse. During observation on 8/12/24 at 3:06 p.m., R17 was lying in bed with their urinary foley catheter tubing draped over their left leg with the catheter bag on the floor without a barrier. During observation on 8/13/24 at 2:35 p.m., R17's urinary foley catheter bag was on the floor without a barrier. During interview on 8/13/24 at 2:54 p.m., licensed practical nurse (LPN)-B stated foley catheter bags were not to be on the ground due to an infection control issue. LPN-B confirmed the bag was on the floor without a barrier. During observation and interview on 8/14/24 at 8:12 a.m., R17's catheter bag which was on the floor and half out of the dignity bag (an opaque bag). Nursing assistant (NA)-C emptied the	21385			

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21385	Continued From page 6 catheter bag, placed the catheter bag inside the dignity bag, and strapped the dignity bag to the bed frame. NA-C stated the foley bag should not have been on the ground but in the dignity bag attached to the frame. During interview on 8/14/24 at 11:32 a.m., the director of nursing (DON) stated that foley catheters should have dignity bags and that foley catheter bags should not be on the ground due to an infection control risk. During interview on 8/15/24 at 1:29 p.m., the infection preventionist (IP) stated the resident had a behavior of picking up the foley bag to weigh it and then placed it on the ground. IP stated in the past they tried different interventions to mitigate the infection risk such as multiple dignity bags or basins for the catheter bag to land in. IP was unaware that this behavior had returned. Policies regarding foley catheters requested, none provided. R33 R33's significant change in status MDS dated 5/8/24, indicated R20 required substantial assistance in all ADLs, the presence of pressure ulcers, and diagnoses which included aphasia (the loss of ability to understand or express speech) and hemiparesis (weakness or the inability to move one side of the body). R33's CP dated 8/12/14, indicated R33 having an unstageable pressure ulcer (full thickness tissue loss where the depth of the wound is completely obscured by eschar); however, the CP did not address EBP.	21385			

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21385	Continued From page 7 R33's order summary report printed 8/14/24, lacked orders regarding EBP. During observation on 8/12/24 at 1:30 p.m., R33's door frame had a magnetic sign indicating R33 was on EBP. During observation on 8/12/24 at 6:54 p.m., NA-E and NA-D completed hand hygiene and donned gloves but did not gown. They repositioned a mechanical lift sling located underneath R33. The mechanical lift was attached to the sling in an appropriate configuration. R33 was raised from chair and moved with mechanical lift to the bed. R33 was lowered then the sling was disconnected from the lift. The mechanical lift sling and pants were partially removed as R33 was rolled to the left where NA-D was positioned. R33 was rolled right with the mechanical lift sling and pants being fulling removed. R33 was placed supine (on back) position, the Velcro on the brief was undone, perineal care was completed by NA-E. R33 was rolled to the left with NA-E completing perineal care. NA-E doffed gloves went to R33's bathroom and donned new gloves. A new brief was positioned under R33. Registered nurse (RN)-D entered the room with gloves donned and with no gown, changed the dressing on R33's coccyx wound, the wound was then cleansed was a saline soaked kerlix, patted dry with another kerlix, and a new dressing applied. RN-D doffed gloves, went in R33's bathroom, and donned new gloves and again did not gown. The dressing on the R33's right elbow was cleansed and dressed in the same manner by RN-D. R33 was placed in the supine position and Nystatin powder was applied to the groin area. NA-E and NA-D attached the Velcro on the brief. The bed height was lowered, the head of bed elevated, and call light placed. Gloves were then doffed by staff.	21385			

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21385	Continued From page 8 During interview on 8/12/24 at 7:33 p.m., RN-D stated that EBP were meant for dealing with wounds that have an active infection like the wound on R33's right leg not regarding other wounds. NA-E and NA-D were both present and in agreement with RN-D. During interview on 8/14/24 at 11:29 a.m., DON stated that staff were to wear a gown and gloves while doing wound and perineal cares for resident's on EBP. During interview on 8/14/24 at 1:48 p.m., IP stated EBP has been rough for the facility, and it has required constant reeducation to staff on wearing personal protective equipment. A facility document titled Enhanced Barrier Precautions (EBP) Protocol undated, indicated to nursing staff "that EBP is needed in the room during high contact care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, indwelling device care/use, wound care." SUGGESTED METHOD OF CORRECTION: The infection preventionist (IP) could develop additional infection control surveillance, teaching and methods to ensure proper use of PPE and catheter bag placement. They could ensure all staff are trained on the importance of PPE and catheter bag placement. Teach and provide surveillance during cares. Audits could be done to ensure that proper PPE use, catheter bag placement and other infection control practices are routinely followed during cares.	21385			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00924	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2024
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21426	Continued From page 10 Findings include: R1's facesheet printed 8/15/24, indicated R1 was admitted on 4/23/24, and included diagnosis of cerebral palsy. R1's significant change Minimum Data Set (MDS) assessment dated 6/12/24, indicated R1's cognition could not be assessed. R1's physician order dated 4/23/24, included 2-step Mantoux if not up to date or completed from transferring facility. R1's treatment administration record (TAR) indicated his first TST was given on 4/24/24. R1's TB screening UDA (user defined assessment) indicated R1 was screened for TB history and risk factors on 4/26/24, two days after he received the first TST (Mantoux). R8's facesheet printed on 8/15/24, indicated R8 was admitted on 12/28/23, and included diagnosis of benign brain tumor. R8's quarterly MDS dated 5/27/24, indicated R8 was cognitively intact. R8's physician order dated 12/28/23, included 2-step Mantoux if not up to date or completed from transferring facility. R8's TAR indicated her first TST was given on 12/28/23. R8's TB screening UDA indicated R8 was screened for TB history and risk factors on 1/3/24, six days after she received the first TST (Mantoux).	21426			

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21426	Continued From page 11 R64 facesheet printed on 8/15/24, indicated R64 was admitted on 3/15/24, and included diagnosis of brain bleed. R64's quarterly MDS dated 7/23/24, indicated R64 had moderately impaired cognition. R64's physician order dated 3/15/24, included 2-step Mantoux if not up to date or completed from transferring facility. R64's TAR indicated his first TST was given on 3/15/24. R64's TB screening UDA indicated R64 was screened for TB history and risk factors on 3/19/24, four days after he received the first TST (Mantoux). During an interview on 8/15/24 at 12:24 p.m., registered nurse (RN)-A who was also the infection preventionist, stated the reason TB screening was completed after the first TST for R1, R8 and R64 was due to the timing of the order to give the Mantoux test and the timing of the screening UDA being triggered for nursing staff to complete. RN-A stated the UDA was currently triggered two days after the first TST and it should trigger on the same day. RN-A stated she was working on trying to get that changed. During an interview on 8/15/24 at 2:50 p.m., the director of nursing (DON) stated she was aware of the TB screening UDA's being completed after the first TST was administered for R1, R8 and R64. In June 2024, the DON created a new checklist for nursing staff which guides the TB screening and testing process to ensure	21426			

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21426	Continued From page 12 screening is completed prior to the first TST. Facility Tuberculosis Control Plan for Residents, dated 5/3/23, indicated newly admitted residents were screened for signs and symptoms of active TB disease. A two-step Mantoux method would be used for TST when testing. Residents with a previously documented positive TST or blood test or history of prior treatment for latent TB infection or active TB disease would receive a chest x-ray to exclude a diagnosis of TB disease. Suggested Method of Correction: The Director of Nursing (DON) or designee could conduct an audit to ensure all residents had received the required baseline tuberculosis (TB) screening prior to the first TST according to facility policy. In addition, the DON or designee could establish a process to ensure adherence to the policy. The DON or designee could educate staff and perform on-going audits to ensure the policy was being followed. Time Period for Correction: Twenty-one (21) days.	21426			
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by:	21695			9/9/24

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
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21695	Continued From page 13 Based on observation, interview, and document review, the facility failed to maintain wheelchairs in a clean and sanitary manner for 2 of 2 residents (R20 and R15) reviewed for safe, clean, comfortable, and home-like environment and for 1 of 1 resident (R31) reviewed who had enteral feeding liquid spilled on the tube feeding (TF) pump and support legs of the pole. Findings include: R20's facesheet printed on 8/15/24, included diagnoses of cerebral hemorrhage (a type of stroke that causes bleeding in the brain), Parkinsonism (movements associated with Parkinson's disease such as stiffness and tremor) and arthritis. R20's quarterly Minimum Data Set (MDS) assessment dated 6/18/24, indicated R20 was cognitively intact, had clear speech, could understand and be understood. R20 required substantial assistance with most activities of daily living (ADL), except eating in which she was independent with set-up help. R20 did not walk and utilized a manual wheelchair. R20's care plan, printed 8/15/24, did not address cleanliness of, or cleaning her wheelchair. During an observation and interview on 8/12/24 at 2:11 p.m., R20 was in her room in her wheelchair eating lunch at a card table. Observed was on her shirt, pants and floor around her wheelchair with spilled food. R20's wheelchair was observed to be soiled with what appeared to be food debris. The stainless steel part of the arm rest was smeared with a light colored material. Crevices of the wheelchair were caked with a pale orange colored material. R20 was unaware of this and	21695	Corrected		

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21695	Continued From page 14 stated she didn't know if anyone cleaned her wheelchair. During an observation and interview on 8/13/24 at 4:09 p.m., with registered nurse (RN)-A, who was also a nurse manager, R20's wheelchair was observed with RN-A. RN-A stated the condition of the wheelchair was unacceptable, and stated wheelchair cleaning was on a schedule where all wheelchairs were cleaned on a regular basis. During an interview on 8/14/24 at 9:34 a.m., the director of nursing (DON) stated she recently developed a checklist for the night shift nursing assistants (NA) to check and clean wheelchairs. The checklist was presented to staff at an all-staff meeting on 7/26/24. The expectation was for NA's to go according to the checklist and clean wheelchairs for blocks of residents each day. During the meeting, the DON showed nursing staff the location of the wheelchair washer and how to operate it. During an interview on 8/14/24 at 10:40 a.m., the DON presented a document titled "NAR (nursing assistant registered) NOC (night) CHECKLIST," which identified the schedule for washing resident wheelchairs. The checklist indicated R20's wheelchair would be washed every Monday. The DON stated she would have expected R20's wheelchair to have been washed on Monday 8/12/24. The DON was informed of the amount of food debris stuck deep into crevices of the wheelchair and had not likely been cleaned for some time. R15's facesheet printed on 8/15/24, included diagnoses of ataxia (impaired coordination). R15's quarterly MDS dated 5/30/24, indicated	21695			

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21695	Continued From page 15 R15 was cognitively intact, had clear speech, could understand and be understood. R15 required substantial assistance for most ADL's. R15 did not walk and used a motorized wheelchair. R20's care plan, printed on 8/15/24, did not address cleanliness of, or cleaning her wheelchair. During an observation and interview on 8/15/24 at 9:47 a.m., in the exercise room for restorative nursing, R15 was observed exercising on a recumbent bike. R15's motorized wheelchair was parked next to her. On observation the foot rest appeared to have rust and debris around perimeters of the foot rest. In addition, the vinyl on both arm rests appeared to have been torn and were secured with tape. (NA)-B, stated R15 went all over with her wheelchair, including locations outside of the facility. NA-B stated since the wheelchair was motorized, it could not go though the wheelchair washer. R15 who had been at the facility less than a year did not recall it having been cleaned and stated it would be nice if it could be cleaned. During an interview on 8/15/24 at 11:46 a.m., the DON was shown photos of R15's wheelchair. The DON stated the chair belonged to R15 and since it was motorized, could not be put in the wheelchair washer, however, expected staff to notice it and clean it and/or report the condition of armrests to someone. During an interview on 8/15/24 at 2:29 p.m., NA-A was not aware of cleanliness of R15's wheelchair, but was aware of the tape on armrests and stated she did not think to bring that to anyone's attention, adding she thought if it was R15's	21695			

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21695	Continued From page 16 wheelchair, R15 wanted it that way. A facility policy for maintenance of resident equipment was requested and not received. R31's quarterly Minimum Data Set, dated 7/15/24, included R31 was cognitively intact and dependent on staff for most activities of daily living with diagnoses of a stroke, malnutrition, and hemiparesis (weakness or inability to move on one side of the body). R31's medical administration record (MAR) and treatment administration records (TAR) for August 2024, indicated R33 received "Isosource 1.5 120 cc x 5 hours via G-tube daily one time a day 600ml total, start at 8 PM, remove at 1:00 AM or after 5 hours, Ok for Jevity 1.5 to replace Isosource 1.5. and remove per schedule." There were no orders regarding cleaning of the TF pump or pole. During observation on 8/12/24 at 2:36 p.m., R31 was lying in bed in their room with TFs not running. The TF pump was attached to a pole with four support legs to the right of the bed. On all the legs, there was a dried brown and tan substance which covered more than 50% on all the legs, the TF pump itself had similar streaks, and several splotches greater than 2-inches on the floor underneath the pole. During interview on 8/12/24 at 2:36 p.m., R31 stated the facility had not cleaned it and that it should be cleaned. During observation and interview on 8/13/24 at 1:48 p.m., the dried brown and tan substance was still present on the pump, pole, and floor.	21695			

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21695	Continued From page 17 R31 expressed disappointment in the lack of cleanliness. During interview on 8/13/24 at 2:03 p.m., nursing assistant (NA)-A stated not knowing who was responsible for cleaning the pole and pump. NA-A verified the condition of the pole, pump, and floor and described it as "gross." During interview on 8/13/24 at 2:49 p.m., housekeeping-A stated to their knowledge the cleaning of TF pumps and poles was not their responsibility. During interview on 8/13/24 at 2:51 p.m., licensed practical nurse (LPN)-A verified the dirty condition of the pole, pump, and floor and stated that it should be cleaned. LPN did not provide an answer on who was responsible for cleaning this equipment. During interview on 8/14/24 at 11:31 a.m., the director of nursing (DON) stated they were not sure whose responsibility it was but would have expected staff to clean if dirty. Cleaning policy regarding TF pump and pole requested, none provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure routine cleaning of wheelchairs. The facility could re-educate nursing staff on the procedure and perform wheelchair cleanliness rounds/audits periodically to ensure wheelchairs are being cleaned. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to	21695			

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21695	Continued From page 18 ensure ongoing compliance. In addition, The administrator, director of nursing, or housekeeping supervisor, or designee could ensure cleanliness of tube feeding equipment and resident floor areas. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure cleaning is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 14, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Innsbruck and Westview Acres, 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	K 000			

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

Electronically Signed

TITLE

(X6) DATE

08/30/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. 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. The original building was constructed in 1979, is three-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2015 addition is three stories in height, has a partial basement and a tunnel leading to the medical facility, is fully fire sprinkler protected and was determined to be of Type II(111) construction.			K 000			

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K 000	Continued From page 2 In April 2016, Floors 2 and 3 have been remodeled 14 beds on each floor, and the center core areas on these floors, including the nurse station and related service areas, commons/dining areas, an Oxygen Room, and a neighborhood kitchen with a Denlar hood on each floor. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 67 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of	K 351		9/30/24	

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K 351	Continued From page 3 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/14/2024, between 10:30 AM and 1:00 PM, it was revealed by observation that there were wires in contact with the sprinkler pipe above the ceiling near the double doors on the 3rd floor at the PAC and on the 1st floor at the double doors be the LTC Elevators. An interview with the Environmental Services Supervisor verified this deficient findings at the time of discovery.	K 351	K351-Sprinkler System-Installation The Environmental Services Director (EVS)/Designee will contact a vendor to remove wires from the sprinkler system. Relocation of the wires from the sprinkler system to meet requirements will be completed upon receipt of bid. Upon receipt of a bid, this PoC will be updated to include the expected completion date. The Administrator/Designee will inspect and verify the wires have been removed from the sprinkler system. The facility QAPI committee will review and oversee documentation that shows the sprinkler system remains in compliance. Compliance date of 9/30/2024		
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend	K 362		9/30/24	

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K 362	Continued From page 4 to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/14/2024 between 10:30 AM and 1:00 PM, it was revealed by observation that there penetrations through the fire wall above the double doors on the 3rd floor near PAC. An interview with the Environmental Services Supervisor verified these deficient findings at the time of discovery.	K 362	K362-Corridors-Construction of Walls The EVS/Designee has sealed the penetrations through the fire wall above the double doors on the 3rd floor near PAC3. The Vendor chosen to complete the work for K351 will inspect all other fire walls for penetrations and will seal them. The Administrator/Designee has inspected the fire walls affected and confirmed the penetrations have been sealed. After any construction that affects the fire walls has been completed the EVS will check the affected walls for penetration and repairs made where necessary. The facility QAPI committee will review and oversee documentation providing validation of repairs have been completed. Compliance date 9/30/24		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric	K 511		9/9/24	

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K 511	Continued From page 5 Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 99 (2012 edition), section 6.3.2.2.1.3(A), NFPA 70 (2011 edition), National Electrical Code, section 110.26(A)(F), 110.27(A)(1), 225.19(C) This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/14/2024, between 10:30 AM and 1:00 PM, it was revealed by observation that the electric panel by Room 322 was being blocked by carts. An interview with the Environmental Services Supervisor verified this deficient finding at the time of discovery.	K 511	K511-Utilities-Gas and Electric The carts that were obstructing the fire panel have been removed. The EVS/Designee has audited the facility electrical panels for obstructions. All non-compliance was corrected on the spot and staff education given to staff. The EVS/Designee has educated staff on the necessity of keeping obstructions by the electrical panels clear for safety purposes. The EVS/Designee will monitor the electrical panels for obstructions weekly for four weeks. Then Monthly after that. The facility QAPI committee will review the audit results and make recommendations and changes where necessary for compliance. K920-Electrical Equipment-Power Cords and Extension Cords The deficient power strips were removed from the Learning Center and items plugged directly into wall outlets by the EVS.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE			STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
(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	
K 511	Continued From page 6	K 511			
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the	K 920	The EVS/Designee will remove non-compliant power strips from the facility and have plugged the appliances into compliant devices or wall outlets. The staff have been educated on the NFPA requirements for power strips by the EVS/Designee. The EVS/Designee will check for noncompliant power strip usage weekly for 2 weeks then monthly after that. The facility QAPI committee will review the results of the walk throughs and make recommendations and changes where necessary. Compliance date 9/9/2024	9/9/24	

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K 920	Continued From page 7 purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 08/14/2024, between 10:30 AM and 1:00 PM, it was revealed by observation that there were two relocatable power strips being used to supply power to building equipment. In the Learning Center, one RPT was being used to power a printer and an additional one was being used to supply power to a microwave and a refrigerator. An interview with the Environmental Services Supervisor verified these deficient finding at the time of discovery.	K 920	K920-Electrical Equipment-Power Cords and Extensions The two relocatable power strips were removed from the Learning Center and the printer, microwave, and refrigerator were plugged directly into wall outlets. The EVS/Designee has audited printers, microwaves, and refrigerators for compliance with the standard for Power Cords and Extensions. Any printer, microwave or refrigerator requiring power strips will have one that meets the NFPA requirements. The EVS has been educated on the proper use of Power Cords and Extensions by the Administrator. The EVS/Designee will look for any noncompliant use of Power Cords and Extensions during their scheduled facility rounds. Any noncompliance will be remedied in a timely manner and reported to the monthly QAPI committee for recommendations and changes where necessary for compliance. Compliance date is 9/9/2024		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and	K 926		9/9/24	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE				STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387			
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K 926	Continued From page 8 cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1, 11.5.2.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/14/2024, between 10:30 AM and 1:00 PM, it was revealed by observations that none of the oxygen filling rooms, had the necessary PPE for staff protection. An interview with the Environmental Services Supervisor verified this deficient finding at the time of discovery.			K 926	K926-Gass Equipment-Qualifications and Training The nursing staff have had medical gas training per NFPA 99 (2012) edition on medical gas usage by the EVS/Designee. The proper PPE necessary for staff safety has been placed in the medical gas rooms per NFPA 99. The EVS/Designee has been educated on the proper PPE necessary for staff safety by the Administrator/Designee. The EVS/Designee will monitor the medical gas storage area for proper PPE and ensure the cleanliness of the PPE monthly. The facility QAPI committee will review the monitoring results and make recommendations and changes where necessary for compliance. Compliance Date 9/9/2024		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 15, 2024

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

RE: CCN: 245234
Cycle Start Date: August 15, 2024

Dear Administrator:

On October 16, 2024, we notified you a remedy was imposed. On November 14, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 6, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 15, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 16, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 15, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 6, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us



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November 15, 2024

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

Re: Reinspection Results
Event ID: EPC712

Dear Administrator:

On September 13, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 15, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us