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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: F6QZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00082

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245595**

2.STATE VENDOR OR MEDICAID NO.
(L2) **017840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WESTBROOK**
(L4) **149 FIRST STREET, BOX 218**
(L5) **WESTBROOK, MN** (L6) **56183**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/11/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **34** (L18)

13.Total Certified Beds **34** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 06/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 07/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/16/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245595

June 19, 2017

Ms. Emily Henderson, Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, MN 56183

Dear Ms. Henderson:

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

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

Effective May 4, 2017 the above facility is recommended for:

34 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 34 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 19, 2017

Ms. Emily Henderson, Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, MN 56183

RE: Project Number S5595027

Dear Ms. Henderson:

On April 27, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 12, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 20, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 12, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 12, 2017, effective May 4, 2017 and therefore remedies outlined in our letter to you dated April 27, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: F6QZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00082

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245595**

2. STATE VENDOR OR MEDICAID NO. (L2) **017840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WESTBROOK**
(L4) **149 FIRST STREET, BOX 218**
(L5) **WESTBROOK, MN** (L6) **56183**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/12/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **34** (L18)

13.Total Certified Beds **34** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	34			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Willson, HFE NE II 05/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/15/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1992** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 26, 2017

Mr. Dennis Dejager, Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, MN 56183

RE: Project Number S5595027

Dear Mr. Dejager:

On April 12, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 22, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 12, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 12, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING _____ B. WING _____	04/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following:	F 309		5/4/17

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

Electronically Signed | 05/04/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING _____ B. WING _____	04/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 residents (R29) reviewed who received hospice services. Findings include: The Minimum Data Set (MDS) assessment dated 3/9/17, for a significant change in status indicated R29 required extensive staff assistance with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS also indicated R29 received hospice services. The hospice plan of care dated 3/1/7, identified the hospice registered nurse (RN) would visit 2-4 times per week for 12 weeks and as needed and the hospice home health aide (HHA) would provide a visit 3-10 times/week for 12 weeks and as needed. The hospice care plan identified the social worker would visit 2 times per month and	F 309	It is the current policy and procedure of Good Samaritan Society Westbrook to ensure coordination between facility and resident's hospice agency of choice. The facility has received a schedule for Hospice Aide visits along with Skilled Nurse visits. The care plan for R29 has been updated to reflect the current Hospice Aide and Skilled Nurse visits. Other residents with current and future hospice election will have their hospice admission paperwork reviewed to ensure coordination between facility and hospice agency. A Hospice Admission Procedure has been developed with the required documentation for hospice election. Facility staff will be educated on the Hospice Admission Procedure by 05/07/17 by the Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING _____ B. WING _____	04/12/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 as needed and the chaplain would visit 1-2 times per month. Emergency contact information was available on the electronic medical record. Review of the facility's form identified as "Scheduled visits" indicated the RN, LPN would visit 2-3 times per week between 9:00 a.m. and 3:00 p.m. and was available for additional visits if needed. A special note on the form specified *if not available to visit on these days, NH staff will be notified by Hospice of Murray County Staff*. It further indicated the home health aide would come Monday-Friday 1-2 visits. It did not identify which days the aide was scheduled nor the scheduled RN days. R29 was observed on 4/11/17, at 12:45 p.m. with family member (F)-A in the beauty shop getting hair fixed. When interviewed at this time, F-A indicated R29 does not have pain but does get anxious. F-A indicated hospice comes every morning for just a little while to make sure she is OK and again in the afternoon. F-A indicated she was not sure when the RN visits but that the hospice RN had been there "this morning". When interviewed on 4/11/17, at 2:17 p.m. the director of nursing (DON) verified the hospice aide comes every morning and sometimes in the afternoon. She indicated they do not know which days there will be an additional visit and the nurse visits are Tuesday through Friday with no scheduled day identified. The DON further indicated that hospice staff do not call prior to inform them of their visit and indicated it could be a problem as R29 sometimes leaves with her daughter.	F 309	Services. Current hospice agency's skilled nurse has been educated on the required coordination between facility and hospice agency on 4/2017. Audits for coordination between facility and hospice agency will be completed 3x/week for 3 weeks then monthly by Director of Nursing Services or designee to ensure continued coordination between facility and resident's elected hospice agency. All audit results will be reviewed by the facility QAPI Committee for further recommendation.	

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	245595	A. BUILDING _____ B. WING _____	04/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 3 When interviewed on 4/11/17, at 2:35 p.m. licensed practical nurse (LPN)-B indicated she was aware of the frequency of hospice nurse visits but did not know which days to expect the visit. LPN-B further confirmed this was the same for the hospice aide schedule, stating, "I only know the frequency. They will call if the aid is sick or can't make it". When interviewed via phone on 4/11/17, at 3:43 p.m. the hospice RN indicated she was unaware there was no schedule nor calendar available for the facility staff. She stated, " I guess we just always come on Tuesdays and Fridays. I guess I assumed". Requested policy and procedure for hospice coordination but not available.	F 309		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 356		5/4/17

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F 356	Continued From page 4 vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post accurate information on the daily nurse staffing document related to the number of certified nurse aides currently working. This had the potential to affect all 25 residents residing in the facility and visitors.	F 356	Accurate information on daily nursing staff hours is publicly posted for residents, families, other staff, and the public for review. All residents and visitors are at a potential risk for the deficient practice.	

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F 356	Continued From page 5 Findings include: During the initial tour of the facility on 4/10/17, at 1:00 p.m. it was noted the nurse staffing information was posted and dated 4/10/17. However, the information did not include an accurate number of certified nursing assistants (NA's) working at this time, (1:00 p.m.). The nurse staffing information was reviewed and identified three (3) NA's were working from 8 a.m. to 2:30 p.m. and/or 6 a.m. to 2:30 p.m. However, when interviewed on 4/10/17, at 1:15 p.m. the licensed practical nurse (LPN)-A verified there were only two (2) NAs working on the floor currently. LPN-A confirmed the posted information was not accurate. It was also observed that only two NAs were working. During an interview on 4/10/17, at 1:30 p.m. registered nurse (RN)-A reported the director of nursing (DON) adjusts the nurse staffing information. RN-A indicated the nursing hours had been reduced as the resident census was less than 31. When interviewed on 4/12/17, at 10:38 a.m. the DON verified the nurse staffing hours posted for 4/10/17, were inaccurate and explained they should be adjusted for call-ins. The DON indicated she attempts to change it throughout the day so that accurate information is posted; however, she was not available when the survey team entered. When the DON is not available there is no system in place to update the nurse staffing information. No policy available for review.	F 356	All Licensed Staff will receive education on the Policy of Nursing Staff Daily Posting Requirements by the Director of Nursing Services. This education will be completed by 05/07/17. The facility has updated the OnShift Program with current nursing staff. The Nursing Staff Daily Posting will be printed from the OnShift Program. Any changes to the daily nursing staff will be updated on the Nursing Staff Posting for accurate staff available daily to provide care for residents. This information will be accurate for review by residents, families, other staff, and the public to view. Audits will be completed 3x/week for 3 weeks then monthly for 3 months by the Director of Nursing Services or designee for daily nursing staff information completion, and also accuracy. All audit results will be reviewed by the facility QAPI Committee for further recommendations.	

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Building 01 of Good Samaritan Society Westbrook was found not to be 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/04/2017

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	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Building 01 of Good Samaritan Society Westbrook was constructed as follows:
The original building was built in 1961, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction;
The first addition was built in 1969, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction;
The second addition was built in 2001, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction
A 2007 building addition, consisting of a new main entrance, lobby and offices. In 2011, the dietary department was fully remodeled. These additions are one-story, have no basement, are fully

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K 000	Continued From page 2 sprinklered and were determined to be of Type V(111) construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a complete automatic fire alarm system, with smoke detection in the corridors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 34 beds and had a census of 25 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 346 SS=D	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be	K 346	RESPONSE: The "out of service" policy for the fire alarm system has been revised. It now has current staff/Fire Marshal Information and the ten hour out of service time has been adjusted. COMPLETION DATE: May 4, 2017 RESPONSIBLE PERSON: The Director of Environmental services will monitor this to	5/4/17

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K 346	Continued From page 3 notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 04/12/2017, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current Staff/Fire Marshal contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346	prevent reoccurrence	
K 354 SS=D	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy.	K 354	RESPONSE: The "out of service" policy for the sprinkler system has been revised. It now has current staff/Fire Marshall information and the ten hour out of service	5/4/17

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K 354	Continued From page 4 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On facility tour between 10:00 AM and 2:00 PM on 04/12/2017, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current Staff/ Fire Marshal contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354	time has been adjusted. COMPLETION DATE: May 4, 2017 RESPONSIBLE PERSON: The Director of Environmental Services will monitor this to prevent reoccurrence.	
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where	K 372		5/4/17

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K 372	Continued From page 5 an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1.(1). This deficient practice could affect 34 of the 34 residents by allowing smoke to propagate from one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 04/12/2017, documentation review revealed that documentation could not be located to show that the smoke and fire dampers recieved an inspection and testing. This is required once every four years.	K 372	RESPONSE: Our HVAC service company has been contacted. They will be onsite within 30 days to inspect and test the fire dampers. They will continue to inspect at least once every 4 years. COMMPLETION DATE: 30days – before 5/31/2017 RESPONSIBLE PERSON: Director of Environmental Services will monitor this to insure inspection occurs at least every 4 years.	

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K 372	Continued From page 6 This deficient practice was verified by the Facility Maintenance Director.	K 372		