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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: HWFS

**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 **08/10/2018** (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:

X 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 | ___ 6. Scope of Services Limit |
| ___ 3. 24 Hour RN | ___ 7. Medical Director |
| ___ 4. 7-Day RN (Rural SNF) | ___ 8. Patient Room Size |
| ___ 5. Life Safety Code | ___ 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 :
Holly Kranz, Unit Supervisor — 08/14/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 08/14/2018 (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

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

CMS Certification Number (CCN): 245595
August 13, 2018

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 July 26, 2018 the above facility is certified 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 13, 2018

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

RE: Project Number S5595028

Dear Ms. Henderson:

On July 17, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 28, 2018. 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 August 10, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 10, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 28, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 26, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 28, 2018, effective July 26, 2018 and therefore remedies outlined in our letter to you dated July 17, 2018, 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,

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

August 13, 2018

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

Re: Reinspection Results - Project Number S5595028

Dear Ms. Henderson:

On August 10, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 28, 2018, with orders received by you on July 17, 2018. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: HWFS

**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 **06/28/2018** (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 :
Lois Boerboom, HFE NE II 08/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/13/2018 (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

Electronically delivered
July 17, 2018

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

RE: Project Number S5595028

Dear Ms. Henderson:

On June 28, 2018, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite 2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

## 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 August 7, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 7, 2018 the following remedy will be imposed:

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

## 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.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 28, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 28, 2018 (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 electronic 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

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245595 | A. BUILDING _____ B. WING _____ | 06/28/2018 |



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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 6/25 - 6/28/18 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On June 25 through June 28, 2018, a standard 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, and Requirements for Long Term Care Facilities.<br><br>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.<br><br>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 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent | F 686 | | 7/26/18 |

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

Electronically Signed | 07/26/2018

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245595 | A. BUILDING _____ B. WING _____ | 06/28/2018 |



| 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 686 | Continued From page 1<br>pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure that 1 of 1 resident (R6) reviewed with a pressure sore, received care consistent with professional standards of practice to promote healing and prevent further pressure ulcer breakdown.<br><br>The findings include:<br><br>R6's admission sheet identified an admit date of 4/15/15 and diagnoses including: Parkinson's Disease, muscle weakness, cognitive communication deficit, depressive disorder, somnolence, edema, dementia and disorientation.<br><br>Review of weekly skin observation documents dated 5/29/18 indicated no skin conditions to coccyx. Skin observation documents dated 6/5/18 and 6/12/18, indicated, "skin check was completed-no conditions observed." A skin observation document dated 6/18/18, indicated a skin issue at "site 23) coccyx." The document included no further description or treatment.<br><br>Review of R6's significant change minimum data set (MDS) assessment dated 4/12/18, indicated R6's cognition was severely impaired, and R6 rarely made decisions. The MDS further | F 686 | F686<br>R6 weekly skin was completed on 7-17-2018 and the pinhole area on his coccyx has healed. The treatment of tegaderm has been reviewed and will continue.<br>To address other residents who may be affected by the deficient practice all weekly skin assessments of the residents have been reviewed. No new issues identified.<br>To ensure systemic measures are put into place, staff will be re-educated by 8-7-18 regarding the need to communicate and implement new interventions for skin integrity and to put measures in place and to follow measures implemented.<br>To monitor performance, random audits will be performed on weekly skin observations and the need to implement interventions by DNS or Designee 3 times a week for 3 weeks then monthly for 3 months.<br>All audit results will be taken to the QAPI Committee for review and further recommendations as needed. | |

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| F 686 | Continued From page 2<br>indicated R6 experienced mild depression, required extensive assitance of one for transfers, hygiene, toileting and dressing; extensive assistance of 2 for bed mobility; and total assistance to eat and move with a wheelchair in the facility. The MDS indicated R6 had a pressure relieving device in the wheelchair and on the mattress in bed, due to a high risk for pressure ulcers, no current pressure ulcers, and no weight loss.<br><br>Review of monthly nursing documentation dated 6/13/18, indicated R6 had potential for skin breakdown, and indicated R6's coccyx had an area that opened up from time to time. The documentation indicated staff used a barrier cream when the coccyx opened "which helps tremendously." There was no indication of any current open areas.<br><br>R6's most recent undated/unsigned physician orders, indicated to check placement of Tegaderm (a type of dressing) to the resident's coccyx daily, and to change the Tegaderm as needed for wound prevention.<br><br>R6's care plan revised 5/17/18, identified a potential for skin impairment related to occasional incontinence of bowel and bladder, decreased physical mobility related to Parkinson's disease, and weakness. The care plan further indicated R6 had a history of two stage 2 pressure areas to the right and left buttocks. Interventions included to keep skin dry, use lotion on dry skin, weekly skin obs (observations) by nurse, and Tegaderm to buttocks changed as needed for prevention of pressure ulcers. The care plan also indicated R6 had pressure relieving and reducing mattress, Rojo (specialized pressure reducing pad) in | F 686 | | |

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| F 686 | Continued From page 3<br>wheel chair, and a reclining wheelchair. In another problem area, R6 was identified as having limited physical mobility related to Parkinson's disease, right shoulder gout, discomfort, and history of Guillan-Barre syndrome. Interventions included:<br>a full lift with 2 assist for transfers, unable to ambulate due to progression of Parkinson's disease, requires one person assist for wheelchair mobility. R6 has an electric reclining chair that staff assist to operate, and requires assistance to reposition self in bed with one to two assistance for side to side positioning, and moving up in bed.<br><br>Review of R6's Treatment Administration Record (TAR) indicated to check placement of Tegaderm to coccyx daily and change as needed for wound prevention. The start date for the Tegaderm was 1/20/18. The TAR for June 2018 indicated placement was checked every day thus far as of 6/28/18.<br><br>Nursing assistant (NA)- A stated during interview on 6/27/18 at 10:10 a.m., that R6 had a pressure ulcer on the coccyx that was healed, but areas were still visible where the Tegaderm was placed. NA-A verified R6 used barrier cream for incontinence protection and prevention of skin breakdown, and Tegaderm on the coccyx daily to prevent pressure ulcers, and confirmed R6 required staff assist with all cares. NA-A said a two person assist was required to transfer R6 from surface to surface with a full body lift, and that R6 recieved passive range of motion daily. She further stated pillows were placed under R6's sides to keep the resident of the coccyx, and that R6 was repositioned every 3 hours, offloaded when refused to lay down, and regularly checked | F 686 | | |

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| F 686 | Continued From page 4<br>for incontinence.<br><br>On 6/28/18, at 10:50 a.m. R6's coccyx was observed. A small pinhole open area with a reddish/pink wound bed was identified over R6's coccyx, nor was a Tegaderm observed in R6's incontinent brief or bedding. No Tegaderm was in place. NA-B stated R6 had not been repositioned since he'd been gotten up that morning. NA-B further stated R6 was assisted to get up by the night shift. Registered nurse (RN)-B was called to R6's room to observe R6's coccyx. RN-B confirmed no Tegaderm was present and verified there was redness, and a pinhole sized open area to the resident's coccyx. RN-B washed hands, applied gloves and cleansed the open area with a peri wipe. No drainage was observed. RN-B removed gloves, left the room to gather supplies, and returned. After washing hands again and applying gloves, the area was cleansed with wound cleanser and gauze and allowed to air dry before a Tegaderm was applied.<br><br>During an interview on 6/28/18, at 11:19 a.m. RN-B was unsure when R6 had last been repositioned, and was unable to determine if the open area was new or an existing open area. RN-B stated R6's coccyx had not been checked yet today because it had been a "really busy morning." RN-B confirmed R6 had a history of pressure ulcers, and used Tegaderm and barrier cream for prevention of open areas. RN-B reviewed R6's June 2018, TAR with the surveyor and verified documentation of daily Tegaderm placement to prevent skin breakdown. A TAR entry dated 6/28/18, indicated R6's coccyx area had been checked on that date for Tegaderm placement however, RN-B verified the Tegaderm placement was not checked before breakfast, | F 686 | | |

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| F 686 | Continued From page 5 | F 686 | | |

and had not been applied due to "lack of time." RN reviewed a facility Follow Up Question Report document with the surveyor which indicated R6 had been repositioned at 7:35 a.m. Progress notes indicated on 6/3/18, two open areas had been discovered on R6's buttocks area, one on the left side near the inside crease, and one near the inside buttock crease. However, upon further chart review, RN-B confirmed there was no other documentation found related to the open areas identified on 6/3/18. RN-B stated all documentation for pressure ulcers was located in the electronic medical record in the user-defined assessments (UDA) tab under skin observations, as well as in progress notes, but none was there related to the new opening or the two areas identified 6/3/18.

During an interview with the director of nursing (DON) on 6/28/18 at 11:57 a.m., the DON stated the processes to assess and monitor pressure injuries were "not set and cut in stone." The DON said the NAs inform the charge nurse if a questionable area of skin is observed, the charge nurse observes the wound, documents in the progress notes, contacts the provider, and communicates findings with RN-A. The DON said if RN-A was unavailable, staff would notify the DON and follow up on the skin concern. The DON added, "If a resident needs immediate medical attention, a physician is informed immediately to determine treatment. If it is not immediate, the nurse treats the wound with house orders, and faxes the physician." The DON said she doesn't expect charge nurses to stage or measure pressure ulcers, but they need to document presence of open skin areas, and implement interventions according to house orders. The DON said Documentation of open

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| F 686 | Continued From page 6<br>areas is completed in the skin observations under the UDA tab, and if a wound is identified on bath day, RN-A is notified, the wound is measured, and monitored on a weekly basis until healed. "If a wound does not respond to the initial treatment, or a wound is complex, a wound nurse is consulted. The wound consultant contacts the facility on an as needed basis and also routinely every month. "<br><br>R6's documentation of skin observations, progress notes, and RN weekly wound observations, were reviewed with the DON on 6/28/18 following the interview. The DON confirmed no follow up documentation was identified in R6's chart regarding the wounds identified 6/3/18. The DON stated she thought RN-A had identified the areas from 6/3/18, as not pressure related, and of no concern, but was unable to locate documentation to indicate if/when the 6/3/18 wounds had been assessed by RN-A, to determine they were not pressure, and or to determine when they resolved. The DON stated follow documentation was supposed to be completed by nursing when a wound was identified. The DON further stated R6 had a preventative treatment and repositioning schedule in the care plan, and stated nursing should be aware of when, and how frequently, residents are repositioned. However, the DON verified no repositioning audits were completed to determine effectiveness of R6's repositioning program, even though R6 had a history of skin breakdown. Finally, the DON acknowleged NA documention of repositioning, may not be accurate due to times when NAs are really busy.<br><br>Review of the facility's Guidelines for Pressure Ulcer Practice Guidelines, indicated all significant | F 686 | | |

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| F 686 | Continued From page 7<br>findings/changes in skin should be reported to the resident's primary care provider by the licensed nurse. "Documentation of primary care provider notification, orders received, family notification and resident response to any treatment should follow ...procedures as well. The location should have a system in place for daily monitoring of pressure ulcers with accompanying documentation from the Wound Data Collection ...when a complication or change is identified. Once a resident experiences a pressure ulcer, an assessment should take place immediately that determines the severity of injury and treatment interventions necessary. Documentation should include the presence of existing Stage I-IV pressure ulcers, other wounds/open areas and or skin conditions (rashes, bruises, cysts, ect.), identification of existing signs of deep tissue injury, which is skin that shows evidence of color, temperature and/or texture changes as compiled to surroundings skin and should be noted, if identified. At the time of assessment, the clinician may determine an ulcer if present, is not consistent with tissue damage associated with unrelieved pressure. When this is the case, the clinician should document the clinical basis differentiating the ulcer (arterial, stasis, diabetic) from a pressure ulcer. It is recommended that the Wound Data Collection ...reflect the nurse's observation and management of wounds from a shift-to-to shift perspective and with each dressing change. At a minimum, weekly documentation is recommended to provide a review of the pressure ulcer/wound. " | F 686 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management. | F 697 | | 7/26/18 |

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| F 697 | Continued From page 8<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to implement interventions to promote comfort and reduce pain for 1 of 1 resident (R17) reviewed for pain management.<br><br>Findings include:<br><br>R17's diagnosis report dated 6/28/18 indicated unstageable pressure ulcer on the left heel and hyperalgesia, and congestive heart failure, and difficulty in walking.<br><br>R17's 30 day Minimum Data Set (MDS) assessment dated 6/6/18, indicated R17 had intact cognition and a pain intensity of four (on a 0-10 pain scale, 10 being the worst pain) that limits day to day activities and makes it hard to sleep at night. R17's Care Area Assessment (CAA) dated 5/3/18, indicated pain was triggered due to resident reporting pain in his whole back along with bilateral upper leg to feet pain, and that R17 reported the pain as frequent.<br><br>R17's physician orders included two PRN (as needed) medication orders:<br>A 4/27/18 order for Tylenol (acetaminophen) tablet 325 milligrams (mg) one tablet, to be given by mouth every six hours as needed for mild, moderate, and severe pain; and a 5/22/18 order for Hydrocodone-Acetaminophen 5/325 mg, one tablet by mouth three times a day as needed for | F 697 | F697<br>Resident R17 has passed away.<br>To identify other residents who may be impacted, all orders for residents with P.R.N pain medications have been reviewed and interventions to promote comfort and reduce pain have been implemented as needed.<br>Staff will be re-educated by 8-7-17 on Pain Management, Data Collection and Assessment and Non-Pharmacological Interventions to promote resident comfort.<br>To monitor performance, random audits will be performed on pain interventions and management by DNS or Designee 3 times weekly for 3 weeks then monthly for 3months. All audit results will be taken to the QAPI Committee for review and further recommendations as needed. | |

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| F 697 | Continued From page 9<br>pain.<br><br>R17's care plan last revised 5/17/18, indicated R17 had an alteration in comfort related to hyperalgesia (hypersensitivity to pain), lower extremity edema, and congestive heart failure evidenced by R17 yelling with movements, transfers and touching the lower extremities (legs and feet). The care plan further indicated R17 was able to call for assistance when in pain, reposition self, and ask for pain medication. Non pharmacological interventions identified included: massage, repositioning, pillows, diversional activities and back rubs.<br><br>According to June 2018 Progress Notes R17 complained of or exhibited symptoms of pain on the following days; 6/1, 6/4, 6/5, 6/6 x 2, 6/8, 6/9 x 2, 6/10, 6/12, 6/13, 6/14, 6/16, 6/18 x 2, 6/19 x 2, 6/20, 6/21 x 2, 6/20, 6/21 x 2, 6/22, 6/23, 6/25, and 6/26/18. However, no nonpharmacological interventions or as needed pain medications were documented as having been used in response to R17's complaints of pain.<br><br>R17's June 2018 Medication Adminstration Record (MAR) revealed R17 received the following:<br>6/2/18, at 7:32 a. m.<br>Hydrocodone-Acetaminophen 5-325 mg one tablet for a pain rating of zero.<br>6/3/18, at 7:33 a. m. Acetaminophen 325 mg for a pain rating of eight.<br>6/4/18, at 7:22 a. m. Acetaminophen 325 mg for a pain rating of seven.<br>6/8/18, at 7:45 a.m.<br>Hydrocodone-Acetaminophen 5/325 mg tablet for a pain rating of five.<br>6/14/18, at 3:45 a.m. | F 697 | | |

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| F 697 | Continued From page 10<br>Hydrocodone-Acetaminophen 5-325 mg Tablet for a pain rating of seven.<br>6/15/18, at 5:13 p.m.<br>Hydrocodone-Acetaminophen 5-325 mg Tablet for a pain rating zero.<br>There was no documented evidence of monitoring whether the medications were effective for reducing R17's pain, and no evidence of how staff identified which medication to use to treat the pain.<br><br>During observation and interview on 6/25/18, at 6:46 p.m., R17 was sitting up in a chair and described his heel pain as "sore as the devil." R17 had a grimacing facial expression.<br><br>During observation of wound care on 6/27/18 at 7:20 a.m., licensed practical nurse (LPN)-A and LPN-B provided dressing change care for R17. During the observation, R17 hollered out, grimaced, pulling his left foot back, and said he had pain with the dressing change. LPN-A confirmed no prn pain medication was given prior to the dressing change.<br><br>On 6/28/18, at 9:12 a. m. registered nurse (RN)-A stated "[R17] has a lot of pain with dressing changes and will get angry and holler. [R17] usually doesn't ask for any pain medication but I usually offer it." RN-A further stated Tylenol is usually given first, and then hydrocodone, but that it really dependended on how bad R17's pain was.<br><br>During interview with the director of nursing (DON) on 6/28/18 at 1:15 p.m., the DON stated, "On 5/17/18 [R17's] provider addressed the pain. Pain assessments are done following a schedule, and pain is asked about during dressing changes. | F 697 | | |

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| F 697 | Continued From page 11<br>If a resident requests a PRN pain medication, the trained medication aide will ask the charge nurse, and the nurse is responsible for following through and giving the medication depending on the type and extent of the pain."<br><br>The facility's policy Pain Management: Data Collection and Assessment, and Non-Pharmacological Pain Interventions last revised 5/17, indicated nurses working directly with a resident must continually monitor and observe the resident for success of the pain management plan, and report to the nurse manager and prescriber as necessary to keep the resident comfortable. | F 697 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced | F 812 | | 7/26/18 |

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| F 812 | Continued From page 12<br>by:<br>Based on observation and interview, the facility failed to ensure proper drying and storage of water pitchers and stainless steel milk servers to prevent bacteria formation and potential for food-borne illness. This deficient practice had the potential to affect all 25 residents residing in the facility.<br><br>Findings include:<br><br>During initial observation of the kitchen with cook-A on 6/25/18, at 12:39 p.m. the following observations were made: Two of four water pitchers were observed uncovered in a kitchen cabinet, in an upright position with approximately an one-eighth-inch of water located at the bottom of the pitchers. Water was also visible on the surface of the shelf surrounding the pitchers. In a lower counter cabinet in the kitchen, four of 20 stainless steel milk servers with attached lids, were layered irregularly on top of a full tray of similar silver containers. The lids of the four top containers were open with water in the bottoms of the containers. During the observation, cook-A confirmed water was present in the pitchers and stainless steel milk servers, and verified the water on the shelf surface where the water pitchers were stored. Cook-A stated it was important that items used to store and serve food, were appropriately dry, and stored upside down or covered in a dry area so as to inhibit bacterial growth. Cook-A was unable to recall when the pitchers and stainless steel containers had last been used, but thought it was likely they were washed after the breakfast meal on 6/25/18.<br><br>During interview with dietary aid (DA)-A on | F 812 | All residents have the potential to be affected by the deficient practice of proper drying and storing of water pitchers and stainless steel milk pitchers<br>To prevent further deficient practice that may affect other resident's re-education of dietary staff will be completed on Mechanical Ware Washing to prevent bacteria formation and the potential for food-borne borne illness. Further food and a Nutrition Competency Checklist will be completed of all dietary staff involved in mechanical ware washing by 08/07/18.<br>To ensure the deficient practice will not occur, random audits will be completed 3 times a week for 3 weeks then monthly for 3 months by the Dietary Manager or designee.<br>Results will be brought to QAPI Committee for further recommendation. | |

| 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 _____ | 06/28/2018 |



| 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 |
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| F 812 | Continued From page 13<br>6/25/18 at 12:30 p.m., DA-A stated the process for drying all serving items such as water pitchers and other containers, was to place them on the drying rack located next to the clean end of the dishwasher to allow them to air dry. DA-A said these items were not to be put away until fully dry to prevent risk for contamination.<br><br>During an interview on 6/27/18 at 9:18 a.m., DA-B stated after the dish washing process, serving items were either left in the wash trays or placed on they drying rack on the clean side of the dish washer and allowed to dry prior to putting them away. DA-B stated the pitchers were used to serve juice on snack carts, and on the medication carts at med pass times. The silver containers with attached lids were used to serve milk at breakfast time. DA-B also stated sometimes the "younger" staff got in a hurry and put items away before they were dry. DA-B said the director of food and nutrition services (DFN) was aware of this and had provided training related to proper drying and storage of dishes.<br><br>During interview on 6/27/18, at 9:40 a.m. the DFN verified the serving containers were supposed to be air-dried and not put away until dry. The DFN acknowledged being aware of issues related to staff putting the pitchers and milk containers in cupboards prior to them being dry. The DFN stated, "we just talked about this." The DFN further stated the pitchers and milk containers were used for both meal service and medication passes.<br><br>The facility policy and procedures for dishwashing and storage were requested but not provided. | F 812 | | |

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|---|---|---|---|
| | 245595 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **06/26/2018** |

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

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101-5145, or | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/26/2018 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| K 000 | Continued From page 1<br><br>By email to:<br>Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us><br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Building 01 of Good Samaritan Society Westbrook was constructed as follows:<br>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;<br>The first addition was built in 1969, is oné-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction;<br>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<br>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 | K 000 | | |

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|---|---|---|---|
| | 245595 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **06/26/2018** |

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| **GOOD SAMARITAN SOCIETY - WESTBROOK** | **149 FIRST STREET, BOX 218**<br>**WESTBROOK, MN 56183** |

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| K 000 | Continued From page 2<br>sprinklered and were determined to be of Type V(111) construction.<br><br>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.<br><br>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.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 324 SS=F | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 | K 324 | | 7/26/18 |

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|---|---|---|---|
| | 245595 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **06/26/2018** |

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| K 324 | Continued From page 3<br>per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and interview the Facility did not ensure that the cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. This deficient practice could effect 25 of the 25 residents.<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. | K 324 | K324: Our kitchen fire suppression service company was contacted. Inspection was completed on 6/27/18 with no issues identified. The Director of Environmental Services will monitor to prevent reoccurrence. | |

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|---|---|---|---|---|
| K 324 | Continued From page 4<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2.<br><br>FINDINGS INCLUDE:<br><br>On facility tour between 10:00 AM and 1:00 PM on 06/26/2018, during documentation review, it was revealed that documentation could not be located to show that the kitchen fire suppression system was inspected within the required time frame. The dates of inspection were 06/22/2017 and 12/06/2017 which is not within the 6 month inspection requirement.<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 324 | | |
| K 711 SS=E | Evacuation and Relocation Plan<br>CFR(s): NFPA 101<br><br>Evacuation and Relocation Plan<br>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.<br>Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.<br>18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and interview, the Facility failed to maintain a Evacuation and Relocation Plan according to the 2012 Life Safety | K 711 | K711: The fire emergency plan was revised on 06/27/18. It now has language requiring employees to call 911 in the | 7/26/18 |

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| K 711 | Continued From page 5<br>Code. This deficient practice could effect 25 of the 25 residents.<br><br>Evacuation and Relocation Plan<br>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.<br>Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3<br><br>FINDINGS INCLUDE:<br><br>On facility tour between 10:00 AM and 1:00 PM on 06/26/2018, during documentation review, it was discovered that the fire emergency plan needs to be updated to include a statement that directs staff to call 911 upon discovery of smoke or fire.<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 711 | event of a fire. Procedure reviewed in QAPI and staff educated as needed. The Director of Environmental Services will monitor to prevent reoccurrence. | |

Electronically delivered

July 17, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5595028

Dear Ms. Henderson:

The above facility was surveyed on June 25, 2018 through June 28, 2018 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 contact Maria King, RN, APM at (507) 344-2716 or maria.king@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00082 | A. BUILDING: _____ B. WING _____ | 06/28/2018 |



| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 000 | Continued From page 1<br><br>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.<br><br>On June 25, 26, 27 and 28, 2018, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.<br><br>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.<br><br>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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |

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| 2 000 | Continued From page 2<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to implement interventions to promote comfort and reduce pain for 1 of 1 resident (R17) reviewed for pain management.<br><br>Findings include:<br><br>R17's diagnosis report dated 6/28/18 indicated unstageable pressure ulcer on the left heel and hyperalgesia, and congestive heart failure, and difficulty in walking.<br><br>R17's 30 day Minimum Data Set (MDS) | 2 830 | Corrected | 8/7/18 |

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| 2 830 | Continued From page 3<br><br>assessment dated 6/6/18, indicated R17 had intact cognition and a pain intensity of four (on a 0-10 pain scale, 10 being the worst pain) that limits day to day activities and makes it hard to sleep at night. R17's Care Area Assessment (CAA) dated 5/3/18, indicated pain was triggered due to resident reporting pain in his whole back along with bilateral upper leg to feet pain, and that R17 reported the pain as frequent.<br><br>R17's physician orders included two PRN (as needed) medication orders:<br>A 4/27/18 order for Tylenol (acetaminophen) tablet 325 milligrams (mg) one tablet, to be given by mouth every six hours as needed for mild, moderate, and severe pain; and a 5/22/18 order for Hydrocodone-Acetaminophen 5/325 mg, one tablet by mouth three times a day as needed for pain.<br><br>R17's care plan last revised 5/17/18, indicated R17 had an alteration in comfort related to hyperalgesia (hypersensitivity to pain), lower extremity edema, and congestive heart failure evidenced by R17 yelling with movements, transfers and touching the lower extremities (legs and feet). The care plan further indicated R17 was able to call for assistance when in pain, reposition self, and ask for pain medication. Non pharmacological interventions identified included: massage, repositioning, pillows, diversional activities and back rubs.<br><br>According to June 2018 Progress Notes R17 complained of or exhibited symptoms of pain on the following days; 6/1, 6/4, 6/5, 6/6 x 2, 6/8, 6/9 x 2, 6/10, 6/12, 6/13, 6/14, 6/16, 6/18 x 2, 6/19 x 2, 6/20, 6/21 x 2, 6/20, 6/21 x 2, 6/22, 6/23, 6/25, and 6/26/18. However, no nonpharmacological interventions or as needed pain medications were | 2 830 | | |

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| 2 830 | Continued From page 4<br>documented as having been used in response to R17's complaints of pain.<br><br>R17's June 2018 Medication Adminstration Record (MAR) revealed R17 received the following:<br>6/2/18, at 7:32 a. m.<br>Hydrocodone-Acetaminophen 5-325 mg one tablet for a pain rating of zero.<br>6/3/18, at 7:33 a. m. Acetaminophen 325 mg for a pain rating of eight.<br>6/4/18, at 7:22 a. m. Acetaminophen 325 mg for a pain rating of seven.<br>6/8/18, at 7:45 a.m.<br>Hydrocodone-Acetaminophen 5/325 mg tablet for a pain rating of five.<br>6/14/18, at 3:45 a.m.<br>Hydrocodone-Acetaminophen 5-325 mg Tablet for a pain rating of seven.<br>6/15/18, at 5:13 p.m.<br>Hydrocodone-Acetaminophen 5-325 mg Tablet for a pain rating zero.<br>There was no documented evidence of monitoring whether the medications were effective for reducing R17's pain, and no evidence of how staff identified which medication to use to treat the pain.<br><br>During observation and interview on 6/25/18, at 6:46 p.m., R17 was sitting up in a chair and described his heel pain as "sore as the devil." R17 had a grimacing facial expression.<br><br>During observation of wound care on 6/27/18 at 7:20 a.m., licensed practical nurse (LPN)-A and LPN-B provided dressing change care for R17. During the observation, R17 hollered out, grimaced, pulling his left foot back, and said he had pain with the dressing change. LPN-A confirmed no prn pain medication was given prior | 2 830 | | |

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| 2 830 | Continued From page 5<br>to the dressing change.<br><br>On 6/28/18, at 9:12 a. m. registered nurse (RN)-A stated "[R17] has a lot of pain with dressing changes and will get angry and holler. [R17] usually doesn't ask for any pain medication but I usually offer it." RN-A further stated Tylenol is usually given first, and then hydrocodone, but that it really dependended on how bad R17's pain was.<br><br>During interview with the director of nursing (DON) on 6/28/18 at 1:15 p.m., the DON stated, "On 5/17/18 [R17's] provider addressed the pain. Pain assessments are done following a schedule, and pain is asked about during dressing changes. If a resident requests a PRN pain medication, the trained medication aide will ask the charge nurse, and the nurse is responsible for following through and giving the medication depending on the type and extent of the pain."<br><br>The facility's policy Pain Management: Data Collection and Assessment, and Non-Pharmacological Pain Interventions last revised 5/17, indicated nurses working directly with a resident must continually monitor and observe the resident for success of the pain management plan, and report to the nurse manager and prescriber as necessary to keep the resident comfortable.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pain to assure they are receiving the necessary treatment/services to prevent pain. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure | 2 830 | | |

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| 2 830 | Continued From page 6<br>management of pain.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure that 1 of 1 resident (R6) reviewed with a pressure sore, received care consistent with professional standards of practice to promote healing and prevent further pressure ulcer breakdown.<br><br>The findings include:<br><br>R6's admission sheet identified an admit date of 4/15/15 and diagnoses including: Parkinson's | 2 900 | corrected | 8/7/18 |

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| 2 900 | Continued From page 7<br><br>Disease, muscle weakness, cognitive communication deficit, depressive disorder, somnolence, edema, dementia and disorientation.<br><br>Review of weekly skin observation documents dated 5/29/18 indicated no skin conditions to coccyx. Skin observation documents dated 6/5/18 and 6/12/18, indicated, "skin check was completed-no conditions observed." A skin observation document dated 6/18/18, indicated a skin issue at "site 23) coccyx." The document included no further description or treatment.<br><br>Review of R6's significant change minimum data set (MDS) assessment dated 4/12/18, indicated R6's cognition was severely impaired, and R6 rarely made decisions. The MDS further indicated R6 experienced mild depression, required extensive assitance of one for transfers, hygiene, toileting and dressing; extensive assistance of 2 for bed mobility; and total assistance to eat and move with a wheelchair in the facility. The MDS indicated R6 had a pressure relieving device in the wheelchair and on the mattress in bed, due to a high risk for pressure ulcers, no current pressure ulcers, and no weight loss.<br><br>Review of monthly nursing documentation dated 6/13/18, indicated R6 had potential for skin breakdown, and indicated R6's coccyx had an area that opened up from time to time. The documentation indicated staff used a barrier cream when the coccyx opened "which helps tremendously." There was no indication of any current open areas.<br><br>R6's most recent undated/unsigned physician orders, indicated to check placement of | 2 900 | | |

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| 2 900 | Continued From page 8<br><br>Tegaderm (a type of dressing) to the resident's coccyx daily, and to change the Tegaderm as needed for wound prevention.<br><br>R6's care plan revised 5/17/18, identified a potential for skin impairment related to occasional incontinence of bowel and bladder, decreased physical mobility related to Parkinson's disease, and weakness. The care plan further indicated R6 had a history of two stage 2 pressure areas to the right and left buttocks. Interventions included to keep skin dry, use lotion on dry skin, weekly skin obs (observations) by nurse, and Tegaderm to buttocks changed as needed for prevention of pressure ulcers. The care plan also indicated R6 had pressure relieving and reducing mattress, Rojo (specialized pressure reducing pad) in wheel chair, and a reclining wheelchair. In another problem area, R6 was identified as having limited physical mobility related to Parkinson's disease, right shoulder gout, discomfort, and history of Guillan-Barre syndrome. Interventions included:<br>a full lift with 2 assist for transfers, unable to ambulate due to progression of Parkinson's disease, requires one person assist for wheelchair mobility. R6 has an electric reclining chair that staff assist to operate, and requires assistance to reposition self in bed with one to two assistance for side to side positioning, and moving up in bed.<br><br>Review of R6's Treatment Administration Record (TAR) indicated to check placement of Tegaderm to coccyx daily and change as needed for wound prevention. The start date for the Tegaderm was 1/20/18. The TAR for June 2018 indicated placement was checked every day thus far as of 6/28/18. | 2 900 | | |

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| 2 900 | Continued From page 9<br><br>Nursing assistant (NA)- A stated during interview on 6/27/18 at 10:10 a.m., that R6 had a pressure ulcer on the coccyx that was healed, but areas were still visible where the Tegaderm was placed. NA-A verified R6 used barrier cream for incontinence protection and prevention of skin breakdown, and Tegaderm on the coccyx daily to prevent pressure ulcers, and confirmed R6 required staff assist with all cares. NA-A said a two person assist was required to transfer R6 from surface to surface with a full body lift, and that R6 recieved passive range of motion daily. She further stated pillows were placed under R6's sides to keep the resident of the coccyx, and that R6 was repositioned every 3 hours, offloaded when refused to lay down, and regularly checked for incontinence.<br><br>On 6/28/18, at 10:50 a.m. R6's coccyx was observed. A small pinhole open area with a reddish/pink wound bed was identified over R6's coccyx, nor was a Tegaderm observed in R6's incontinent brief or bedding. No Tegaderm was in place. NA-B stated R6 had not been repositioned since he'd been gotten up that morning. NA-B further stated R6 was assisted to get up by the night shift. Registered nurse (RN)-B was called to R6's room to observe R6's coccyx. RN-B confirmed no Tegaderm was present and verified there was redness, and a pinhole sized open area to the resident's coccyx. RN-B washed hands, applied gloves and cleansed the open area with a peri wipe. No drainage was observed. RN-B removed gloves, left the room to gather supplies, and returned. After washing hands again and applying gloves, the area was cleansed with wound cleanser and gauze and allowed to air dry before a Tegaderm was applied.<br><br>During an interview on 6/28/18, at 11:19 a.m. | 2 900 | | |

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| 2 900 | Continued From page 10<br><br>RN-B was unsure when R6 had last been repositioned, and was unable to determine if the open area was new or an existing open area. RN-B stated R6's coccyx had not been checked yet today because it had been a "really busy morning." RN-B confirmed R6 had a history of pressure ulcers, and used Tegaderm and barrier cream for prevention of open areas. RN-B reviewed R6's June 2018, TAR with the surveyor and verified documentation of daily Tegaderm placement to prevent skin breakdown. A TAR entry dated 6/28/18, indicated R6's coccyx area had been checked on that date for Tegaderm placement however, RN-B verified the Tegaderm placement was not checked before breakfast, and had not been applied due to "lack of time." RN reviewed a facility Follow Up Question Report document with the surveyor which indicated R6 had been repositioned at 7:35 a.m. Progress notes indicated on 6/3/18, two open areas had been discovered on R6's buttocks area, one on the left side near the inside crease, and one near the inside buttock crease. However, upon further chart review, RN-B confirmed there was no other documentation found related to the open areas identified on 6/3/18. RN-B stated all documentation for pressure ulcers was located in the electronic medical record in the user-defined assessments (UDA) tab under skin observations, as well as in progress notes, but none was there related to the new opening or the two areas identified 6/3/18.<br><br>During an interview with the director of nursing (DON) on 6/28/18 at 11:57 a.m., the DON stated the processes to assess and monitor pressure injuries were "not set and cut in stone." The DON said the NAs inform the charge nurse if a questionable area of skin is observed, the charge nurse observes the wound, documents in the | 2 900 | | |

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| 2 900 | Continued From page 11<br>progress notes, contacts the provider, and communicates findings with RN-A. The DON said if RN-A was unavailable, staff would notify the DON and follow up on the skin concern. The DON added, "If a resident needs immediate medical attention, a physician is informed immediately to determine treatment. If it is not immediate, the nurse treats the wound with house orders, and faxes the physician." The DON said she doesn't expect charge nurses to stage or measure pressure ulcers, but they need to document presence of open skin areas, and implement interventions according to house orders. The DON said Documentation of open areas is completed in the skin observations under the UDA tab, and if a wound is identified on bath day, RN-A is notified, the wound is measured, and monitored on a weekly basis until healed. "If a wound does not respond to the initial treatment, or a wound is complex, a wound nurse is consulted. The wound consultant contacts the facility on an as needed basis and also routinely every month. "<br><br>R6's documentation of skin observations, progress notes, and RN weekly wound observations, were reviewed with the DON on 6/28/18 following the interview. The DON confirmed no follow up documentation was identified in R6's chart regarding the wounds identified 6/3/18. The DON stated she thought RN-A had identified the areas from 6/3/18, as not pressure related, and of no concern, but was unable to locate documentation to indicate if/when the 6/3/18 wounds had been assessed by RN-A, to determine they were not pressure, and or to determine when they resolved. The DON stated follow documentation was supposed to be completed by nursing when a wound was identified. The DON further stated R6 had a | 2 900 | | |

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| 2 900 | Continued From page 12<br><br>preventative treatment and repositioning schedule in the care plan, and stated nursing should be aware of when, and how frequently, residents are repositioned. However, the DON verified no repositioning audits were completed to determine effectiveness of R6's repositioning program, even though R6 had a history of skin breakdown. Finally, the DON acknowleged NA documention of repositioning, may not be accurate due to times when NAs are really busy.<br><br>Review of the facility's Guidelines for Pressure Ulcer Practice Guidelines, indicated all significant findings/changes in skin should be reported to the resident's primary care provider by the licensed nurse. "Documentation of primary care provider notification, orders received, family notification and resident response to any treatment should follow ...procedures as well. The location should have a system in place for daily monitoring of pressure ulcers with accompanying documentation from the Wound Data Collection ...when a complication or change is identified. Once a resident experiences a pressure ulcer, an assessment should take place immediately that determines the severity of injury and treatment interventions necessary. Documentation should include the presence of existing Stage I-IV pressure ulcers, other wounds/open areas and or skin conditions (rashes, bruises, cysts, ect.), identification of existing signs of deep tissue injury, which is skin that shows evidence of color, temperature and/or texture changes as compiled to surroundings skin and should be noted, if identified. At the time of assessment, the clinician may determine an ulcer if present, is not consistent with tissue damage associated with unrelieved pressure. When this is the case, the clinician should document the clinical basis differentiating the ulcer (arterial, stasis, diabetic) | 2 900 | | |

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| 2 900 | Continued From page 13<br>from a pressure ulcer. It is recommended that the Wound Data Collection ...reflect the nurse's observation and management of wounds from a shift-to-to shift perspective and with each dressing change. At a minimum, weekly documentation is recommended to provide a review of the pressure ulcer/wound. "<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 900 | | |
| 21134 | MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage<br><br>Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination.<br><br>This MN Requirement is not met as evidenced | 21134 | | 8/7/18 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 21134 | Continued From page 14<br>by:<br>Based on observation and interview, the facility failed to ensure proper drying and storage of water pitchers and stainless steel milk servers to prevent bacteria formation and potential for food-borne illness. This deficient practice had the potential to affect all 25 residents residing in the facility.<br><br>Findings include:<br><br>During initial observation of the kitchen with cook-A on 6/25/18, at 12:39 p.m. the following observations were made: Two of four water pitchers were observed uncovered in a kitchen cabinet, in an upright position with approximately an one-eighth-inch of water located at the bottom of the pitchers. Water was also visible on the surface of the shelf surrounding the pitchers. In a lower counter cabinet in the kitchen, four of 20 stainless steel milk servers with attached lids, were layered irregularly on top of a full tray of similar silver containers. The lids of the four top containers were open with water in the bottoms of the containers. During the observation, cook-A confirmed water was present in the pitchers and stainless steel milk servers, and verified the water on the shelf surface where the water pitchers were stored. Cook-A stated it was important that items used to store and serve food, were appropriately dry, and stored upside down or covered in a dry area so as to inhibit bacterial growth. Cook-A was unable to recall when the pitchers and stainless steel containers had last been used, but thought it was likely they were washed after the breakfast meal on 6/25/18.<br><br>During interview with dietary aid (DA)-A on 6/25/18 at 12:30 p.m., DA-A stated the process | 21134 | corrected | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00082 | A. BUILDING: _____ B. WING _____ | 06/28/2018 |



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| 21134 | Continued From page 15<br>for drying all serving items such as water pitchers and other containers, was to place them on the drying rack located next to the clean end of the dishwasher to allow them to air dry. DA-A said these items were not to be put away until fully dry to prevent risk for contamination.<br><br>During an interview on 6/27/18 at 9:18 a.m., DA-B stated after the dish washing process, serving items were either left in the wash trays or placed on they drying rack on the clean side of the dish washer and allowed to dry prior to putting them away. DA-B stated the pitchers were used to serve juice on snack carts, and on the medication carts at med pass times. The silver containers with attached lids were used to serve milk at breakfast time. DA-B also stated sometimes the "younger" staff got in a hurry and put items away before they were dry. DA-B said the director of food and nutrition services (DFN) was aware of this and had provided training related to proper drying and storage of dishes.<br><br>During interview on 6/27/18, at 9:40 a.m. the DFN verified the serving containers were supposed to be air-dried and not put away until dry. The DFN acknowledged being aware of issues related to staff putting the pitchers and milk containers in cupboards prior to them being dry. The DFN stated, "we just talked about this." The DFN further stated the pitchers and milk containers were used for both meal service and medication passes.<br><br>The facility policy and procedures for dishwashing and storage were requested but not provided.<br><br>SUGGESTED METHOD OF CORRECTION: The dietary manager, or designee, could update/create policies and procedures related to | 21134 | | |

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| 21134 | Continued From page 16<br>dishwashing and storage of dishes, and could educate staff regarding any revisions.The dietary manager, or designee, could perform audits periodically, to ensure implementation of protocols.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21134 | | |