DEPARTMENT OF	HEALTH AI	MEDICA	N SERVICES ARE/MEDICA TO BE COMP			ND TRAN	SMITTAL	DICARE & N	IEDICAID SERVICES ID: HWFS Facility ID: 00082
1. MEDICARE/MEDICAL	D PROVIDER NO	Э.	3. NAME AND A			FETDDOOL		4. TYPE OF	FACTION: <u>7 (</u> L8)
(L1) 245595	EDICAIDNO		(L3) GOOD SAN (L4) 149 FIRST			ESTBROOK		1. Initial	2. Recertification
2.STATE VENDOR OR M (L2) 017840300	EDICAID NO.		(L5) WESTBRC		A 210	(L6)	56183	3. Termina 5. Validatio 7. On-Site	on 6. Complaint
5. EFFECTIVE DATE CH	ANGE OF OWN	ERSHIP	7. PROVIDER/S	UPPLIER CATE	GORY	<u>02</u> (L'	7)		
(L9)			01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA	8. Full Sur	vey After Complaint
6. DATE OF SURVEY	08/10/2	018 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			DENDING DATE: (125)
8. ACCREDITATION STA	ATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC			R ENDING DATE: (L35)
0 Unaccredited 2 AOA	1 TJC 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	6	12/3	31
11LTC PERIOD OF CER	TIFICATION		10.THE FACILIT	Y IS CERTIFIED	AS:				
From (a):			X A. In Compl	ance With		And/Or App	roved Waivers Of	The Following Ro	equirements:
To (b) :			Program F	equirements		2. Te	echnical Personnel	6. Sec	ope of Services Limit
			Complian	e Based On:		3. 24	Hour RN	7. Me	edical Director
12 Total Facility Dada		34 (L18)	1	Acceptable POC		4. 7-1	Day RN (Rural SN	NF) 8. Pati	ient Room Size
12. Total Facility Beds		34 (L18) 34 (L17)				5. Li	fe Safety Code	<u> </u>	ds/Room
13.Total Certified Beds		34 (L17)	B. Not in Com Requirement	oliance with Progr s and/or Applied	am Waivers:	* Code:	Α	(L12)	
14. LTC CERTIFIED BED	BREAKDOWN					15. FACILITY	Y MEETS		
18 SNF	18/19 SNF 34	19 SNF	ICF	IID		1861 (e) (1)	or 1861 (j) (1):	(L1	15)
(L37)	(L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGE	ENCY REMARKS	S (IF APPLICA	BLE SHOW LTC C	ANCELLATION	DATE):				
17. SURVEYOR SIGNAT	URE		Date :			18. STATE SU	URVEY AGENCY	APPROVAL	Date:
Holly Kranz, L	Jnit Superv	isor		08/14/2018	(L19)	K <u>amala Fisl</u>	<u>ke-Downing, I</u>	Enforcement	Specialist 08/14/2018 (L20)
	PART I	I - TO BE	COMPLETED	BY HCFA R	EGIONAL	OFFICE C	OR SINGLE S	TATE AGEN	ICY
19. DETERMINATION O	F ELIGIBILITY			MPLIANCE WIT	H CIVIL		Statement of Fina		
1. Facility is	Eligible to Partici	pate	RIG	HTS ACT:			Ownership/Contro Both of the Above		ure Stmt (HCFA-1513)
2. Facility is		(L21)							
22. ORIGINAL DATE	23.	LTC AGREEN	MENT	4. LTC AGREE	MENT	26. TERMIN	JATION ACTION	:	(L30)
OF PARTICIPATION		BEGINNING	DATE	ENDING DA	TE	VOLUNTARY	r 00) IN	IVOLUNTARY
01/01/1992		52000000		LIDING DI		01-Merger, Cl		_	5-Fail to Meet Health/Safety
		(1.41)		(1.25)			tion W/ Reimburs		5-Fail to Meet Agreement
(L24)	-	(L41)		(L25)			oluntary Terminatio	n	
25. LTC EXTENSION DA	ATE: 27.		VE SANCTIONS				on for Withdrawal	0	<u>THER</u> 7-Provider Status Change
		A. Suspension	n of Admissions:	(1.4.4))-Active
				(L44)				00	

 (L27)
 B. Rescind Suspension Date:

 (L45)

 28. TERMINATION DATE:
 29. INTERMEDIARY/CARRIER NO.

 06201

 (L28)

 (L28)

 (L21)

 31. RO RECEIPT OF CMS-1539

 32. DETERMINATION OF APPROVAL DATE

 (L32)

 (L33)

 DETERMINATION APPROVAL



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,

Kumala Piske 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: <u>Kamala.Fiske-Downing@state.mn.us</u>



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,

Kumala 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



Protecting, Maintaining and Improvingthe 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

	ARE/MEDICAID CERTIF		ND TRANSM	AITTAL	DICARE & MEDICA	AID SERVICES	
PART I 1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245595 2.STATE VENDOR OR MEDICAID NO. (L2) 017840300	- TO BE COMPLETED BY 3. NAME AND ADDRESS OF I (L3) GOOD SAMARITAN S (L4) 149 FIRST STREET, B (L5) WESTBROOK, MN	FACILITY Society - Wi			F 4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	acility ID: 00082 N: <u>2 (</u> L8) 2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 06/28/2018 (L34)	7. PROVIDER/SUPPLIER CAT 01 Hospital 05 HHA 02 SNF/NF/Dual 06 PRTF	TEGORY 09 ESRD 10 NF	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint	
0. DATE OF SURVEY 00/20/2016 (L34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 00 FRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	11 ICF/IID	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN 12/31	IG DATE: (L35)	
11LTC PERIOD OF CERTIFICATION From (a) :	10.THE FACILITY IS CERTIFII A. In Compliance With	ED AS:	And/Or Approv	ved Waivers Of	The Following Requireme	nts:	

Program Requirements

Compliance Based On:

X B. Not in Compliance with Program

ICF

(L42)

Date :

34 (L18)

34 (L17)

19 SNF

(L39)

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

(L21)

23. LTC AGREEMENT

(L41)

(L28)

(L32)

BEGINNING DATE

27. ALTERNATIVE SANCTIONS

A. Suspension of Admissions:

B. Rescind Suspension Date:

1. Acceptable POC

Requirements and/or Applied Waivers:

08/10/2018

20. COMPLIANCE WITH CIVIL

24. LTC AGREEMENT

ENDING DATE

(L25)

(L44)

(L45)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

06201

RIGHTS ACT:

IID

(L43)

(L19)

(L31)

(L33)

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

FORM CMG 1520	(7.04)	(Destance Dails a Editions)
FORM CMS-1539	(/-84)	(Destroy Prior Editions)

То

(b):

12. Total Facility Beds

13. Total Certified Beds

18 SNF

(L37)

22. ORIGINAL DATE

01/01/1992

(L24)

OF PARTICIPATION

25. LTC EXTENSION DATE:

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539

17. SURVEYOR SIGNATURE

14. LTC CERTIFIED BED BREAKDOWN

18/19 SNF

34

(L38)

Lois Boerboom, HFE NE II

1. Facility is Eligible to Participate

(L27)

19. DETERMINATION OF ELIGIBILITY

Facility is not Eligible

6. Scope of Services Limit

Date:

(L30)

05-Fail to Meet Health/Safety

06-Fail to Meet Agreement

07-Provider Status Change

INVOLUNTARY

OTHER

00-Active

08/13/2018

(L20)

7. Medical Director

8. Patient Room Size

9. Beds/Room

(L15)

(L12)

2. Technical Personnel

4. 7-Day RN (Rural SNF)

3. 24 Hour RN

15. FACILITY MEETS

21

VOLUNTARY

30. REMARKS

01-Merger, Closure

* Code:

____ 5. Life Safety Code

1861 (e) (1) or 1861 (j) (1):

B*

18. STATE SURVEY AGENCY APPROVAL

3. Both of the Above :

26. TERMINATION ACTION:

02-Dissatisfaction W/ Reimbursement

DETERMINATION APPROVAL

03-Risk of Involuntary Termination

04-Other Reason for Withdrawal

Kamala Fiske-Downing, Enforcement Specialist

00

1. Statement of Financial Solvency (HCFA-2572)

2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)



Protecting, Maintaining and Improvingthe Health of All Minnesotans

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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		F	NTED: 07/30/2018 FORM APPROVED B NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
245595 NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WESTBROOK	11	STREET ADDRESS, CITY, STATE, ZIP CODE	06/28/20 <u>18</u>
		VESTBROOK, MN 56183 PROVIDER'S PLAN OF CORRECTION	()(5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 000 Initial Comments	E 000		
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. F 000 INITIAL COMMENTS	F 000		
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.	5		
The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.			
 Upon receipt of an acceptable electronic POC, a 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 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer SS=D CFR(s): 483.25(b)(1)(i)(ii) 	0		7/26/18
 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent 			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S S Electronically Signed	DIGINATURE	TITLE	(X6) DATE 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.

TATEMEN	T OF DEFICIENCIES DF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION (X3) DA). 0938-039 TE SURVEY MPLETED
		245595 ER TY - WESTBROOK		TREET ADDRESS, CITY, STATE, ZIP CODE 49 FIRST STREET, BOX 218	/28/20 <u>18</u>
GOOD S	SAMARITAN SOCIE	IT - WESTBROOK	N	/ESTBROOK, MN 56183	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 686	Continued From	page 1	F 686		
	ulcers unless the demonstrates the (ii) A resident wit necessary treatm with professiona promote healing new ulcers from This REQUIREM by: Based on obser review, the facilit resident (R6) re received care co standards of pra prevent further p The findings incl R6's admission s 4/15/15 and diag Disease, muscle communication of somnolence, ede disorientation. Review of weekl dated 5/29/18 in coccyx. Skin ob 6/5/18 and 6/12/ completed-no co observation docu skin issue at "site included no furth Review of R6's s set (MDS) asses R6's cognition w	IENT is not met as evidenced vation, interview and document by failed to ensure that 1 of 1 viewed with a pressure sore, nsistent with professional ctice to promote healing and ressure ulcer breakdown.		F686 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. 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. 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. 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. All audit results will be taken to the QAPI Committee for review and further recommendations as needed.	

Facility ID: 00082

If continuation sheet Page 2 of 14

STATEMENT	COF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
				REET ADDRESS, CITY, STATE, ZIP CODE	06/	28/20 <u>18</u>
GOODS	AMARITAN SOCIE	TY - WESTBROOK	WE	STBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 686	indicated R6 exp required extensiv hygiene, toileting assistance of 2 f assistance to ea the facility. The pressure relievin on the mattress pressure ulcers, no weight loss. Review of month 6/13/18, indicate breakdown, and area that opened documentation in cream when the tremendously." current open are R6's most recent orders, indicated Tegaderm (a typ coccyx daily, and needed for wour R6's care plan re potential for skin incontinence of k physical mobility and weakness. R6 had a history the right and left to keep skin dry, skin obs (observ to buttocks chan pressure ulcers. had pressure rel	A period of the second state of the second sta	F 686			

If continuation sheet Page 3 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X) IDENTIFICATION NUMBER: (X) MULTIPLE CONSTRUCTION A. BUILDING (X) OWNER A. BUILDING (X) OWNER COMPLETED (X) OWNER COMPLETED <td< th=""><th></th><th></th><th>I AND HUMAN SERVICES E & MEDICAID SERVICES</th><th></th><th></th><th>FORM</th><th>07/30/2018 APPROVED 0938-0391</th></td<>			I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/30/2018 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE GOOD SAMARITAN SOCIETY - WESTBROOK 149 FIRST STREET, BOX 218 WESTBROCK, NM 55183 Image: Control of the control							
Form Strate / Approximation GOD SAMARITAN SOCIETY - WESTBROOK Strate: ZP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183 (PALID) TAG ELANDARICONY MUST RE PRECEDED BY FULL RECH DEPICIENCY PREFIX TAG PROVIDER'S ALL CORRECTION (CROSS-REFERENCED D'THE APPROPRIATE DEFICIENCY) OWNED DATE F 686 Continued From page 3 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: 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. F 686 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 120:18 at To:10 a.m., that R6 had a pressure ulcer on the coccyx that was healed, but areas were still visible where the Tegaderm to incontinence protection and prevention of skin breakdown, and Tegaderm on the coccyx daily to prevent pressure ulcers, and confirmed P6 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 recleved passive range of motion daily. <td></td> <td></td> <td>245595</td> <td>B. WING</td> <td></td> <td>06/2</td> <td>28/2018</td>			245595	B. WING		06/2	28/2018
GODD SAMARTITAN SOCIETY - WESTBROOK WESTBROOK, MN 56183 (%4) ID PREEK TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATIONY OF LSC DENTIFYING INFORMATION) PD PREEK TAG PROVIDERS FULL OF CORRECTION (EACH CORRECTIVE AND CORRECTION (EACH CORRECTIVE AND CORRECTION REGULATIONY OF LSC DENTIFYING INFORMATION) PB PREEK TAG PROVIDERS FULL OF CORRECTION (EACH CORRECTIVE AND CORRECTIVE AND CORRECTIVE (EACH CORRECTIVE AND CORRECTIVE AND CORRECTIVE (EACH CORRECTIVE AND CORRECTIVE AND CORRECTION (EACH CORRECTIVE AND CORRECTIVE AND CORRECTIVE AND CORRECTIVE (EACH CORRECTIVE AND CORRECTIVE (EACH CORRECTIVE AND CORRECTIVE (EACH CORRECTIVE AND CORRECTIVE (EACH CORRECTIVE (EACH CORRECTIVE (EACH CORRECTIVE (EACH CORRECTIVE (EACH CORRECTIVE (EACH CORRECTIVE (EACH CORRECTIVE (E	NAME OF F	PROVIDER OR SUPPLIER					
Pieževi TAg (EACH OPERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG (EACH CORRECTIVE ACTION SHOUD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) construction DEFICIENCY) F 686 Continued From page 3 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: 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 for side to side positioning, and moving up in bed. Review of R6's Treatment Administration Record (TAR) indicated to check placement of Tegaderm was 1/20/18. The TAR for June 2018 indicated placement was checked every day thus far as of 6/28/18. 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 daily to prevent pressure ulcers, and confirmed R6 required staff assist twas healed, but areas were still visible where the Tegaderm on the coccyx daily to prevent pressure ulcers, and confirmed R6 required staff assist twas nealed, but areas were still visible where the 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 recleved passive range of motion daily.	GOOD S	AMARITAN SOCIETY	- WESTBROOK		-		
 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 synforme. Interventions included: 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 to reposition self in bed with one to two assistance to reposition self of bed with one to two assistance to reposition self of bed with one to two assistance to reposition self of bed with one to two assistance to reposition self of bed with one to two assistance to reposition self of bed with one to two assistance for hold the forth Ergaderm was 1/20/18. The TAR for June 2018 indicated placement was checked every day thus far as of 6/28/18. 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 to voparted 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 to assist R6 from surface with a full body lift, and that R6 recleved passive range of motion daily. 	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
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	F 686	wheel chair, and a another problem au having limited phys Parkinson's diseas discomfort, and his syndrome. Interve a full lift with 2 assi ambulate due to pr disease, requires wheelchair mobility chair that staff assi assistance to repose two assistance for moving up in bed. Review of R6's Tre (TAR) indicated to to coccyx daily and prevention. The st 1/20/18. The TAR placement was che 6/28/18. Nursing assistant (on 6/27/18 at 10:10 ulcer on the coccyy were still visible wh NA-A verified R6 u incontinence prote- breakdown, and Te prevent pressure u required staff assis two person assist of from surface to sur that R6 recieved pa She further stated sides to keep the r	reclining wheelchair. In rea, R6 was identified as sical mobility related to e, right shoulder gout, tory of Guillan-Barre ntions included: st for transfers, unable to ogression of Parkinson's one person assist for 7. R6 has an electric reclining st to operate, and requires sition self in bed with one to side to side positioning, and atment Administration Record check placement of Tegaderm I change as needed for wound art date for the Tegaderm was for June 2018 indicated ecked every day thus far as of NA)- A stated during interview 0 a.m., that R6 had a pressure c that was healed, but areas here the Tegaderm was placed. sed barrier cream for ction and prevention of skin egaderm on the coccyx daily to lcers, and confirmed R6 it with all cares. NA-A said a was required to transfer R6 face with a full body lift, and assive range of motion daily. pillows were placed under R6's esident of the coccyx, and that	F 686			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/30/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		245595	B. WING		06/;	28/2018
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK		49 FIRST STREET, BOX 218 VESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 686	Continued From pa for incontinence.	age 4	F 686			
	observed. A small reddish/pink wound coccyx, nor was a incontinent brief or place. NA-B stated since he'd been go further stated R6 w night shift. Registe to R6's room to obs confirmed no Tega there was redness to the resident's co applied gloves and peri wipe. No drain removed gloves, le and returned. Afte applying gloves, the wound cleanser an before a Tegaderm During an interview RN-B was unsure w repositioned, and w open area was new RN-B stated R6's o yet today because morning." RN-B co pressure ulcers, ar cream for prevention reviewed R6's June and verified docum placement to prevention placement to prevention placement howeve	50 a.m. R6's coccyx was pinhole open area with a d bed was identified over R6's Tegaderm observed in R6's bedding. No Tegaderm was in d R6 had not been repositioned tten up that morning. NA-B vas assisted to get up by the ered nurse (RN)-B was called serve R6's coccyx. RN-B derm was present and verified , and a pinhole sized open area ccyx. RN-B washed hands, cleansed the open area with a age was observed. RN-B ft the room to gather supplies, r washing hands again and e area was cleansed with d gauze and allowed to air dry was applied. <i>v</i> on 6/28/18, at 11:19 a.m. when R6 had last been was unable to determine if the v or an existing open area. coccyx had not been checked it had been a "really busy nfirmed R6 had a history of nd used Tegaderm and barrier on of open areas. RN-B e 2018, TAR with the surveyor ientation of daily Tegaderm ent skin breakdown. A TAR 8, indicated R6's coccyx area on that date for Tegaderm r, RN-B verified the Tegaderm r, RN-B verified the Tegaderm				

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STATEMENT	RS FOR MEDICA OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DAT	0938-039 E SURVEY PLETED
	PROVIDER OR SUPPLI	245595 ER TY - WESTBROOK	149	REET ADDRESS, CITY, STATE, ZIP CODE 9 FIRST STREET, BOX 218 ESTBROOK, MN 56183	06/	28/20 <u>18</u>
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 686	and had not bee RN reviewed a fa document with th had been reposit notes indicated of been discovered the left side near the inside buttoc chart review, RN documentation fa identified on 6/3/ documentation fa the electronic me assessments (U as well as in pro- related to the ne identified 6/3/18. During an intervi (DON) on 6/28/1 the processes to injuries were "no said the NAs info questionable are nurse observes fa progress notes, communicates fi said if RN-A was the DON and fol DON added, "If a medical attention immediately to d immediate, the r orders, and faxe she doesn't exper implement intervi	n applied due to "lack of time." acility Follow Up Question Report the surveyor which indicated R6 tioned at 7:35 a.m. Progress on 6/3/18, two open areas had on R6's buttocks area, one on the inside crease, and one near k crease. However, upon further I-B confirmed there was no other bund related to the open areas 18. RN-B stated all or pressure ulcers was located in edical record in the user-defined DA) tab under skin observations, gress notes, but none was there w opening or the two areas	F 686			

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	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		X3) DATE SURVEY COMPLETED
		245595	B. WING	EINI	06/28/20 <u>18</u>
NAME OF F	PROVIDER OR SUPPLIE	R		REET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S.	AMARITAN SOCIE	TY - WESTBROOK		FIRST STREET, BOX 218 STBROOK, MN 56183	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC
F 686	Continued From	page 6	F 686		
	the UDA tab, and day, RN-A is noti and monitored or a wound does no or a wound is con consulted. The w facility on an as r every month. " R6's documentat progress notes, a observations, we 6/28/18 following confirmed no foll identified following confirmed no foll identified 6/3/18. RN-A had identifi pressure related, unable to locate of if/when the 6/3/18 RN-A, to determine or to determine w stated follow doc completed by nur identified. The D preventative trea schedule in the of should be aware residents are rep verified no repos determine effecti program, even th breakdown. Fina documention of r	ed in the skin observations under I if a wound is identified on bath fied, the wound is measured, in a weekly basis until healed. "If it respond to the initial treatment, mplex, a wound nurse is wound consultant contacts the needed basis and also routinely ion of skin observations, and RN weekly wound re reviewed with the DON on the interview. The DON ow up documentation was chart regarding the wounds The DON stated she thought ed the areas from 6/3/18, as not and of no concern, but was documentation to indicate 8 wounds had been assessed by ne they were not pressure, and when they resolved. The DON umentation was supposed to be rsing when a wound was ON further stated R6 had a tment and repositioning are plan, and stated nursing of when, and how frequently, ositioned. However, the DON itioning audits were completed to veness of R6's repositioning ough R6 had a history of skin ally, the DON acknowleged NA epositioning, may not be imes when NAs are really busy.			

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TATEMEN	OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		3 NO. 0938-039 DATE SURVEY COMPLETED
	PROVIDER OR SUPPLIE	245595	B. WING	EET ADDRESS, CITY, STATE, ZIP CODE	06/28/20 <u>18</u>
	AMARITAN SOCIET		149	FIRST STREET, BOX 218 STBROOK, MN 56183	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 686	resident's primary nurse. "Docume notification, order and resident resp followprocedur have a system in pressure ulcers v documentation fr when a complic Once a resident of assessment should determines the se include the prese pressure ulcers, of skin conditions (r identification of e injury, which is se temperature and/ to surroundings se identified. At the clinician may dete consistent with tis unrelieved presse clinician should d differentiating the from a pressure of the Wound Data observation and a shift-to-to shift pe dressing change. documentation is review of the prese Pain Management	in skin should be reported to the y care provider by the licensed ntation of primary care provider 's received, family notification bonse to any treatment should es as well. The location should place for daily monitoring of with accompanying om the Wound Data Collection cation or change is identified. experiences a pressure ulcer, an uld take place immediately that everity of injury and treatment essary. Documentation should nce of existing Stage I-IV other wounds/open areas and or ashes, bruises, cysts, ect.), xisting signs of deep tissue sin that shows evidence of color, for texture changes as compiled skin and should be noted, if time of assessment, the ermine an ulcer if present, is not sue damage associated with ure. When this is the case, the ocument the clinical basis e ulcer (arterial, stasis, diabetic) ulcer. It is recommended that Collectionreflect the nurse's management of wounds from a erspective and with each At a minimum, weekly recommended to provide a ssure ulcer/wound. "	F 686		7/26/18

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STATEMENT	RS FOR MEDICAL OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		3 NO. 0938-039 3) DATE SURVEY COMPLETED
NAME OF I	PROVIDER OR SUPPLIE	245595 ER	B. WING S	TREET ADDRESS, CITY, STATE, ZIP CODE	06/28/20 <u>18</u>
GOOD S	AMARITAN SOCIE	TY - WESTBROOK		49 FIRST STREET, BOX 218 VESTBROOK, MN 56183	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 697	The facility must provided to resid consistent with p the comprehensia and the residents This REQUIREN by: Based on obserr review the facility interventions to p for 1 of 1 resider management. Findings includes R17's diagnosis unstageable press hyperalgesia, and difficulty in walkin R17's 30 day Mir assessment date intact cognition a 0-10 pain scale, limits day to day sleep at night. R (CAA) dated 5/3/ due to resident re along with bilater R17's physician on needed) medicat A 4/27/18 order f tablet 325 milligr by mouth every s moderate, and so for Hydrocodone	ensure that pain management is ents who require such services, rofessional standards of practice, we person-centered care plan, s' goals and preferences. IENT is not met as evidenced vation, interview, and document / failed to implement promote comfort and reduce pain at (R17) reviewed for pain t (R17)	F 697	F697 Resident R17 has passed away. To identify other residents who may b 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. Staff will be re-educated by 8-7-17 on Pain Management, Data Collection ar Assessment and Non-Pharmacologic Interventions to promote resident com To monitor performance, random aud will be performed on pain intervention and management by DNS or Designe times weekly for 3 weeks then month 3months. All audit results will be take the QAPI Committee for review and further recommendations as needed.	e al ifort. its s e 3 y for

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		AND HUMAN SERVICES			FORM	07/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245595	B. WING		06/:	28/2018
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		<u></u>
GOOD S	AMARITAN SOCIETY	- WESTBROOK		49 FIRST STREET, BOX 218 VESTBROOK, MN 56183		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 697	Continued From papain.	age 9	F 697			
	R17 had an alterati hyperalgesia (hype extremity edema, a evidenced by R17 transfers and touch and feet). The care was able to call for reposition self, and pharmacological in	t revised 5/17/18, indicated on in comfort related to rsensitivity to pain), lower and congestive heart failure yelling with movements, hing the lower extremities (legs e plan further indicated R17 assistance when in pain, ask for pain medication. Non terventions identified included: ning, pillows, diversional rubs.				
	complained of or e. the following days; 2, 6/10, 6/12, 6/13, 6/20, 6/21 x 2, 6/20 and 6/26/18. Howe interventions or as documented as hav R17's June 2018 M Record (MAR) reve following: 6/2/18, at 7:32 a. m Hydrocodone-Acet tablet for a pain ra 6/3/18, at 7:33 a. m pain rating of eight 6/4/18, at 7:22 a. m pain rating of seven 6/8/18, at 7:45 a.m	ledication Adminstration ealed R17 received the aminophen 5-325 mg one ting of zero. a. Acetaminophen 325 mg for a b. Acetaminophen 325 mg for a c. aminophen 5/325 mg tablet for				

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If continuation sheet Page 10 of 14

TATEMENT	RS FOR MEDICAL OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DAT	. 0938-039 E SURVEY IPLETED
	PROVIDER OR SUPPLIE	245595	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	06/	/28/20 <u>18</u>
	AMARITAN SOCIE		14	9 FIRST STREET, BOX 218 ESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 697	for a pain rating of 6/15/18, at 5:13 p Hydrocodone-Ac for a pain rating a There was no do monitoring wheth effective for redu evidence of how to use to treat the During observatio 6:46 p.m., R17 w described his het R17 had a grima During observatio 7:20 a.m., license LPN-B provided During the obser grimaced, pulling had pain with the confirmed no pro- to the dressing c On 6/28/18, at 9: stated "[R17] has changes and will usually doesn't a usually offer it." usually given firs it really depended was. During interview (DON) on 6/28/12 "On 5/17/18 [R17 Pain assessmen	etaminophen 5-325 mg Tablet of seven. D.m. etaminophen 5-325 mg Tablet zero. cumented evidence of her the medications were cing R17's pain, and no staff identified which medication e pain. On and interview on 6/25/18, at ras sitting up in a chair and el pain as "sore as the devil." cing facial expression. On of wound care on 6/27/18 at ed practical nurse (LPN)-A and dressing change care for R17. vation, R17 hollered out, his left foot back, and said he dressing change. LPN-A pain medication was given prior	F 697			

TAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATEDATEF 697Continued From page 11 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."F 697F 697			I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 07/30/2018 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - WESTBROOK STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183 (X4) ID PREFIX CALL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH OBERCIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETIC COMPLETIC DATE F 697 Continued From page 11 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." F 697	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DAT	E SURVEY
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 OERRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (x5) COMPLETING DATE F 697 Continued From page 11 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." F 697			245595	B. WING		06/	28/2018
GOOD SAMARITAN SOCIETY - WESTBROOK 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) COMPLETIC DATE F 697 Continued From page 11 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." F 697	NAME OF	PROVIDER OR SUPPLIER					
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COMPLÉTIC DATEF 697Continued From page 11 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."F 697	GOOD S	AMARITAN SOCIETY	- WESTBROOK				
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."	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
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 812 7/26/18 F 812 Food Procurement, Store/Prepare/Serve-Sanitary SS=F F 812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) F 812 7/26/18 \$483.60(i) Food safety requirements. The facility must - \$483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. F 812 7/26/18 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. F 10 F 10 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not proclude residents from consuming foods not procured by the facility. \$483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced F 812	F 812	If a resident request trained medication and the nurse is re and giving the medi and extent of the p The facility's policy Collection and Asse Non-Pharmacologi revised 5/17, indication with a resident must observe the resident management plan, manager and prese resident comfortab Food Procurement CFR(s): 483.60(i)(1 §483.60(i) Food sa The facility must - §483.60(i)(1) - Proc approved or consident state or local author (i) This may include from local produce and local laws or re (ii) This provision of facilities from using gardens, subject to safe growing and fe (iii) This provision of from consuming fo §483.60(i)(2) - Stor serve food in accor standards for food	ests a PRN pain medication, the aide will ask the charge nurse, sponsible for following through lication depending on the type ain." Pain Management: Data essment, and cal Pain Interventions last ated nurses working directly st continually monitor and nt for success of the pain and report to the nurse criber as necessary to keep the le. ,Store/Prepare/Serve-Sanitary 1)(2) fety requirements. cure food from sources lered satisfactory by federal, orities. e food items obtained directly rs, subject to applicable State egulations. loes not prohibit or prevent g produce grown in facility o compliance with applicable pod-handling practices. does not preclude residents ods not procured by the facility. re, prepare, distribute and rdance with professional service safety.				7/26/18

TATEMENT	OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLI	245595 ER TY - WESTBROOK	B. WING _	STREET ADDRESS, CITY, STATE, ZIP C 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183	18	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET	
F 812	by: Based on obser failed to ensure water pitchers and prevent bacteria food-borne illnes potential to affect facility. Findings include During initial observations we pitchers were observations we surface of the shi lower counter can stainless steel m were layered irres similar silver cor containers were the containers. It confirmed water stainless steel m on the shelf surfa- were stored. Cool items used to stee appropriately dry covered in a dry growth. unable to recall we steel containers was likely they we meal on 6/25/18	evation and interview, the facility proper drying and storage of nd stainless steel milk servers to formation and potential for ss. This deficient practice had the et all 25 residents residing in the servation of the kitchen with 18, at 12:39 p.m. the following re made: Two of four water pserved uncovered in a kitchen oright position with approximately ch of water located at the bottom Water was also visible on the nelf surrounding the pitchers. In a abinet in the kitchen, four of 20 nilk servers with attached lids, egularly on top of a full tray of ntainers. The lids of the four top open with water in the bottoms of During the observation, cook-A was present in the pitchers and nilk servers, and verified the water ace where the water pitchers ok-A stated it was important that ore and serve food, were <i>x</i> , and stored upside down or area so as to inhibit bacterial Cook-A was when the pitchers and stainless had last been used, but thought it were washed after the breakfast	F 81	2 All residents have the poter affected by the deficient pra drying and storing of water stainless steel milk pitchers To prevent further deficient may affect other resident's in dietary staff will be complete Mechanical Ware Washing bacteria formation and the p food-borne borne illness. Fu a Nutrition Competency Che completed of all dietary staff mechanical ware washing b To ensure the deficient prace occur, random audits will be times a week for 3 weeks th 3 months by the Dietary Ma designee. Results will be brought to Q Committee for further recom	ctice of proper bitchers and practice that e-education of ed on to prevent botential for urther food and ecklist will be f involved in y 08/07/18. tice will not e completed 3 en monthly for nager or	

		HAND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/30/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		245595	B. WING		06/:	28/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 812	for drying all servin and other contained drying rack located dishwasher to allow these items were r to prevent risk for of During an interview stated after the dis items were either I on they drying rack washer and allowe away. DA-B stated serve juice on sna carts at med pass with attached lids w breakfast time. DA "younger" staff got before they were d food and nutrition s this and had provid drying and storage During interview on verified the serving be air-dried and no acknowledged bein staff putting the pit cupboards prior to stated, "we just tall further stated the p were used for both passes. The facility policy a	m., DA-A stated the process ag items such as water pitchers rs, was to place them on the d next to the clean end of the w them to air dry. DA-A said not to be put away until fully dry contamination. v on 6/27/18 at 9:18 a.m., DA-B h washing process, serving eft in the wash trays or placed c on the clean side of the dish d to dry prior to putting them the pitchers were used to ck carts, and on the medication times. The silver containers were used to serve milk at -B also stated sometimes the in a hurry and put items away ry. DA-B said the director of services (DFN) was aware of led training related to proper	F 812			

If continuation sheet Page 14 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

75895027

PRINTED: 07/30/2018 FORM APPROVED OMB NO. 0938-0391

D PLAN Ö	F CORRECTION	IDENTIFICATION NUMBER:	ABUILDING	01 - MAIN BUILDING 01	COMPLETED	
	ROVIDER OR SUPPLIER	245595	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE		/26/2018
	AMARITAN SOCIETY	- WESTBROOK	1	49 FIRST STREET, BOX 218 VESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 000			
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Divisi Building 01 of Goo Westbrook was fou with the requireme Medicare/Medicaid 483.70(a), Life Saf edition of National (NFPA) Standard 1	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, d Samaritan Society and not to be in compliance nts for participation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association I01, Life Safety Code (LSC), g Health Care Occupancies.				
	DEFICIENCIES (K	OR THE FIRE SAFETY -TAGS) TO:		EPOC		
	Health Care Fire Ir State Fire Marshal 445 Minnesota Stro St. Paul, MN 5510	Division eet, Suite 145		LFU		
RATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 07/26/2

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	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G 01 - MAIN BUILDING 01	CON	IPLETED
		245595	B. WING		06	/26/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
GOOD S	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
K 000	Continued From pa	age 1	K 00	0		
	Angela.Kappenma	itney@state.mn.us> and				
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:				
	1. A description of whether to correct the deficie	what has been, or will be, done iency.				
	2. The actual, or pr	oposed, completion date.				
		or title of the person rection and monitoring to ence of the deficiency.		~		
	Westbrook was co The original buildin one-story, has no b protected and was II(222) construction	d Samaritan Society nstructed as follows: ig was built in 1961, is basement, is fully fire sprinkler determined to be of Type n; vas built in 1969, is oné-story,				
	and was determine construction; The second additic one-story, has no b	is fully fire sprinkler protected ed to be of Type II(222) on was built in 2001, is pasement, is fully fire sprinkler determined to be of Type				
	V(111) construction A 2007 building ad entrance, lobby an department was fu					

Facility ID: 00082

If continuation sheet Page 2 of 6

PRINTED: 07/30/2018

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPLE CONSTR			0. 0938-039 TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '	ING 01 - MAIN		CO	MPLETED
		245595	B. WING	1			/26/2018
IAME OF F	PROVIDER OR SUPPLIER	····			DRESS, CITY, STATE, ZIP C	ODE	
BOOD S	AMARITAN SOCIETY	- WESTBROOK			STREET, BOX 218 OOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x (E/	PROVIDER'S PLAN OF COF ACH CORRECTIVE ACTION DSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
K 000	V(111) construction	re determined to be of Type	ĸ	000			
	building as allowed Fire Protection Ass	e being surveyed as one in the 2012 edition of National ociation (NFPA) Standard 101, .SC), Chapter 19 Existing pancies.					
	system, with smoke in spaces open to t monitored for autor notification. The fac	omplete automatic fire alarm e detection in the corridors and the corridors, which is matic fire department cility has a capacity of 34 beds of 25 at time of the survey.					
	The requirement at NOT MET as evide Cooking Facilities CFR(s): NFPA 101	t 42 CFR, Subpart 483.70(a) is enced by:		324			7/26/18
	with NFPA 96, Star and Fire Protection Operations, unless * residential cookin appliances such as toasters) are used cooking in accorda * cooking facilities compartments with	t is protected in accordance dard for Ventilation Control of Commercial Cooking is g equipment (i.e., small s microwaves, hot plates, for food warming or limited ince with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke a 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3,					
	* cooking facilities 30 or fewer patient 18.3.2.5.4, 19.3.2.5	in smoke compartments with s comply with conditions under 5.4. protected according to NFPA 96					

Facility ID: 00082

If continuation sheet Page 3 of 6

PRINTED: 07/30/2018

	OF DEFICIENCIES	E & MEDICAID SERVICES		LE CONSTRUCTION	MB NO.		
	OF DEFICIENCIES	IDENTIFICATION NUMBER:	• •	01 - MAIN BUILDING 01		PLETED	
		245595	B. WING		06/2	26/2018	
AME OF	PROVIDER OR SUPPLIER	<u>.</u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
SOOD S	AMARITAN SOCIET	(- WESTBROOK	149 FIRST STREET, BOX 218 WESTBROOK, MN 56183				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
K 324	Continued From p	age 3	K 324				
	per 9.2.3 are not re	equired to be enclosed as but shall not be open to the					
	18.3.2.5.1 through 19.3.2.5.5, 9.2.3, 1	18.3.2.5.4, 19.3.2.5.1 through ПА 12-2					
	by: Based on docume the Facility did not equipment is prote 96, Standard for V	ENT is not met as evidenced entation review and interview ensure that the cooking ected in accordance with NFPA entilation Control and Fire		K324: Our kitchen fire suppressi service company was contacted. Inspection was completed on 6/2 no issues identified. The Director	7/18 with of		
		mercial Cooking Operations. tice could effect 25 of the 25		Environmental Services will moni prevent reoccurrence.	tor to		
	with NFPA 96, Sta and Fire Protection Operations, unless * residential cookin appliances such a toasters) are used cooking in accorda * cooking facilities compartments with with the conditions or	ng equipment (i.e., small s microwaves, hot plates, for food warming or limited ance with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke h 30 or fewer patients comply s under 18.3.2.5.3, 19.3.2.5.3,					
	30 or fewer patien 18.3.2.5.4, 19.3.2. Cooking facilities per 9.2.3 are not r	in smoke compartments with ts comply with conditions under 5.4. protected according to NFPA 96 equired to be enclosed as but shall not be open to the					

Facility ID: 00082

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU			0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	· · /	ING 01 - MAIN BUILDING 01		PLETED
		245595	B. WING		06/	26/2018
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
iood s.	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 324	Continued From pa	age 4	КЗ	324		
	18.3.2.5.1 through 19.3.2.5.5, 9.2.3, T	18.3.2.5.4, 19.3.2.5.1 through IA 12-2.				
	FINDINGS INCLU	DE:				
	on 06/26/2018, dur was revealed that located to show the system was inspect frame. The dates of	ween 10:00 AM and 1:00 PM ring documentation review, it documentation could not be at the kitchen fire suppression sted within the required time of inspection were 06/22/2017 hich is not within the 6 month ment.	,č			
	This deficient prac Maintenance Direc Evacuation and Re CFR(s): NFPA 101	elocation Plan	K.	711		7/26/18
	patients and for the an emergency. Employees are pe informed with their copy of the plan is operator or with se basic response red and provides for al components per 1 18.7.1.1 through 1 18.7.2.3, 19.7.1.1 19.7.2.2, 19.7.2.3 This REQUIREME by: Based on docume the Facility failed to	blan for the protection of all eir evacuation in the event of riodically instructed and kept duties under the plan, and a readily available with telephone ecurity. The plan addresses the quired of staff per 18/19.7.2.1.2 Il of the fire safety plan		K711: The fire emergence revised on 06/27/18. It no requiring employees to ca	w has language	

TEMENT	OF DEFICIENCIES	KANDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y /		CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED	
D PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING 0	1 - MAIN BUILDING 01			
		245595	B. WING			06/:	26/2018	
AME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			REET ADDRESS, CITY, STATE, ZIP CODE			
	AMARITAN SOCIETY	- WESTBROOK	149 FIRST STREET, BOX 218					
				w	ESTBROOK, MN 56183			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE	
K 711	Continued From pa	Continued From page 5		711				
	Code. This deficient practice could effect 25 of the 25 residents. Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 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 FINDINGS INCLUDE:				event of a fire. Procedure reviewed QAPI and staff educated as neede Director of Environmental Services	d. The		
					monitor to prevent reoccurrence.			
	on 06/26/2018, dur was discovered that needs to be update directs staff to call or fire.	deficient practice was verified by the Facility						

Facility ID: 00082

If continuation sheet Page 6 of 6

PRINTED: 07/30/2018



Protecting, Maintaining and Improving the Health of All Minnesotans

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. § 144A.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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

PRINTED: 07/30/2018 FORM APPROVED

Minnesc	Minnesota Department of Health							
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00082		B. WING		- 06/2	28/201 <u>8</u>	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WESTBROOK		STREET, B DOK, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETE DATE	
2 000	Initial Comments			2 000				
	*****ATTE	ENTION*****						
	NH LICENSING CORRECTION ORDER							
	144A.10, this correct pursuant to a surver found that the define herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN R When a rule conta comply with any of lack of compliance re-inspection with a result in the assess	n Minnesota Statute, s ection order has been ey. If, upon reinspect ciency or deficiencies rected, a fine for each be assessed in acco fines promulgated by partment of Health. whether a violation has compliance with all e rule provided at the ule number indicated ins several items, failut the items will be conse. Lack of compliance any item of multi-part sment of a fine even i luring the initial inspect	issued ion, it is cited violation rdance rule of been tag below. ure to sidered upon rule will f the item					
	that may result from orders provided the the Department wi	t hearing on any asset m non-compliance wit at a written request is thin 15 days of receip ent for non-complianc	h these made to t of a					
	receipt of State lice the Minnesota Dep Informational Bulle http://www.health.s obul.htm The Sta delineated on the a	o participate in the ele	ent with t rofinfo/inf					
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVI ically Signed	DER/SUPPLIER REPRESEN	TATIVE'S SIGN	IATURE	TITLE		(X6) DATE 07/26/18	

If continuation sheet 1 of 17

PRINTED: 07/30/2018 FORM APPROVED

Minneso	ta Department of He	ealth					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00082		B. WING		06/2	8/201 <u>8</u>
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK		OOK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 000	Continued From pa	age 1		2 000			
	Department of Hea you electronically. is necessary for St enter the word "con text. You must then State licensure pro completion date, th corrected prior to e Minnesota Department's s and the following c Please indicate in y correction that you and identify the dat Minnesota Department the State Licensing federal software. T	alth orders being subr Although no plan of o rate Statutes/Rules, p rrected" in the box av n indicate in the election ocess, under the heac ne date your orders w electronically submitting	correction lease ailable for ronic ling ill be ng to the eyors of e provider ssued. f orders, ompleted. umenting sing en				
Ainnesota D	Nursing Homes. The assigned tag r column entitled "II statute/rule out of o "Summary Stateme and replaces the " correction order. T findings which are after the statement evidence by." Follo are the Suggested Time period for Co PLEASE DISREG/ FOURTH COLUMI "PROVIDER'S PL/ APPLIES TO FED	number appears in th D Prefix Tag." The sta compliance is listed ir ent of Deficiencies" c To Comply" portion of his column also inclu in violation of the stat t, "This Rule is not me owing the surveyors fi Method of Correctior	e far left ate olumn the des the te statute et as ndings n and OF THE N." THIS				

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Minnesota Department of Health										
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NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
GOOD S	AMARITAN SOCIETY	- WESTBROOK		T STREET, E OOK, MN 56						
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE			
2 000	Continued From page 2			2 000						
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.									
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General			2 830			8/7/18			
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident re and treatment, pers supervision based of d preferences as ide resident assessmen scribed in parts 4658, ing home resident mu possible unless ther he attending physicia ain in bed or the residen bed.	sonal and n ntified in t and .0400 and ust be out e is a an that the							
	by: Based on observat review the facility fa interventions to pro	ent is not met as evi ion, interview, and do ailed to implement mote comfort and red R17) reviewed for pa	ocument duce pain		Corrected					
	Findings include:									
	unstageable pressi	port dated 6/28/18 inc ure ulcer on the left h congestive heart failu	eel and							
	-	num Data Set (MDS)								
/innesota D	epartment of Health									
Minnesc	ta Department of He	ealth								
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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	ED.	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
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NAME OF I	PROVIDER OR SUPPLIER	ST	TREET ADD	RESS, CITY, S	TATE, ZIP CODE					
GOOD S	AMARITAN SOCIETY			STREET, B OK, MN 56						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE			
2 830	Continued From pa	age 3		2 830						
	intact cognition and 0-10 pain scale, 10 limits day to day ac sleep at night. R17 (CAA) dated 5/3/18 due to resident rep along with bilateral R17 reported the p R17's physician or needed) medicatio A 4/27/18 order for tablet 325 milligram by mouth every six moderate, and sev for Hydrocodone-A	ders included two PRN ((on a nat rd to ent ggered back and that (as n) e given ild, order g, one							
	R17 had an alterat hyperalgesia (hyperalgesia (hyperalgesia (hyperalgesia (hyperalgesia (hyperalgesia)) extremity edema, a evidenced by R17 transfers and touch and feet). The car was able to call for reposition self, and pharmacological in massage, reposition activities and back According to June complained of or e the following days; 2, 6/10, 6/12, 6/13, 6/20, 6/21 x 2, 6/20 and 6/26/18. How	at revised 5/17/18, indica- ion in comfort related to presensitivity to pain), lowe and congestive heart fail- yelling with movements, ning the lower extremitie e plan further indicated F assistance when in pair I ask for pain medication terventions identified inco- pring, pillows, diversiona rubs. 2018 Progress Notes R ⁺ xhibited symptoms of pair 6/1, 6/4, 6/5, 6/6 x 2, 6/8 6/14, 6/16, 6/18 x 2, 6/1 0, 6/21 x 2, 6/22, 6/23, 6/ ever, no nonpharmacolo needed pain medication	er ure s (legs R17 n, n. Non cluded: al 17 ain on 8, 6/9 x 19 x 2, /25, pgical							

STATEMEN	DIA Department of H NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
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NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 4	2 830			
	documented as ha R17's complaints o	iving been used in response to of pain.				
	Record (MAR) rev following: 6/2/18, at 7:32 a. r Hydrocodone-Acet tablet for a pain ra 6/3/18, at 7:33 a. r pain rating of eight 6/4/18, at 7:22 a. r pain rating of seve 6/8/18, at 7:45 a.r Hydrocodone-Acet for a pain rating of 6/14/18, at 3:45 a. Hydrocodone-Acet for a pain rating of 6/15/18, at 5:13 p. Hydrocodone-Acet for a pain rating ze There was no doct monitoring whethe effective for reduct	taminophen 5-325 mg one ating of zero. n. Acetaminophen 325 mg for a t. n. Acetaminophen 325 mg for a n. Acetaminophen 325 mg for a n. taminophen 5/325 mg tablet for e. m. taminophen 5-325 mg Tablet seven. m. taminophen 5-325 mg Tablet ero. umented evidence of r the medications were ing R17's pain, and no taff identified which medication	ı			
	6:46 p.m., R17 wa described his heel	n and interview on 6/25/18, at s sitting up in a chair and pain as "sore as the devil." ng facial expression.				
	7:20 a.m., licensed LPN-B provided d During the observa grimaced, pulling h had pain with the c	n of wound care on 6/27/18 at d practical nurse (LPN)-A and lressing change care for R17. ation, R17 hollered out, his left foot back, and said he dressing change. LPN-A bain medication was given prior				

Minnesota De	epartment of He	ealth					
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GOOD SAMAI	RITAN SOCIETY	- WESTBROOK		T STREET, B OOK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	=ULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETE DATE
2 830 Con	tinued From pa	age 5		2 830			
to th	ne dressing cha	inge.					
statı cha usu usu usu usu	ed "[R17] has a nges and will go ally doesn't ask ally offer it." Ri ally given first, a ally dependend	2 a.m. registered nurs lot of pain with dress et angry and holler. [R for any pain medicati N-A further stated Tyle and then hydrocodone ed on how bad R17's	ing 17] on but I enol is e, but that				
(DC "On Pair and If a trair and and	N) on 6/28/18 a 5/17/18 [R17's assessments pain is asked a resident reques the medication the nurse is re	th the director of nursi at 1:15 p.m., the DON] provider addressed to are done following a sabout during dressing sts a PRN pain medica aide will ask the charge sponsible for following lication depending on ain."	stated, the pain. schedule, changes. ation, the ge nurse, g through				
Coll Non revis with obse mar mar	ection and Asso Pharmacologi sed 5/17, indica a resident mus erve the residen nagement plan,	cal Pain Interventions ated nurses working d st continually monitor a nt for success of the p and report to the nurs criber as necessary to	last irectly and bain se				
The all rece prev desi deliv	director of nursesidents at risk eiving the neces vent pain. The ignee, could co very of care; to vices are impler	THOD OF CORRECT sing or designee, coul for pain to assure the ssary treatment/servic director of nursing or nduct random audits ensure appropriate ca mented; to better ensu	d review ey are es to of the are and				

Minneso	ta Department of He	ealth					
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GOOD S	AMARITAN SOCIETY	- WESTBROOK		r street, e ook, mn 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 6		2 830			
	management of pa	in.					
	TIME PERIOD FOI (21) days.	R CORRECTION:	Twenty-one				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab -	Pressure	2 900			8/7/18
	Subp. 3. Pressure comprehensive res of nursing services development of a n provides that:	ident assessment must coordinate t	, the director he				
	A. a resident wh without pressure s pressure sores unle condition demonstr authenticates, that	ess the individual' rates, and a physic	elop s clinical :ian				
	B. a resident w receives necessar promote healing, pr new sores from dev	revent infection, a	ervices to				
	This MN Requirem by: Based on observative review, the facility for the facility for the facility for the facility for the free term of the facility for the fac	ion, interview and ailed to ensure that wed with a pressu istent with profess ce to promote hea ssure ulcer breakd e: eet identified an ac	document at 1 of 1 ire sore, ional ling and lown.		corrected		
/innesota D	4/15/15 and diagno	oses including: Par	KINSON'S				

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Minnesc	ta Department of H	ealth				
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GOOD S	AMARITAN SOCIETY	- WESIBBOOK	9 FIRST STRE ESTBROOK, M	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL LSC IDENTIFYING INFORMATION		TX (EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	communication de somnolence, edem disorientation. Review of weekly s dated 5/29/18 indic coccyx. Skin obse 6/5/18 and 6/12/18 completed-no cond observation docum skin issue at "site 2 included no further Review of R6's sig set (MDS) assess	skin observation docume cated no skin conditions t ervation documents dated b, indicated, "skin check v ditions observed." A skin nent dated 6/18/18, indica 23) coccyx." The docume description or treatment nificant change minimum nent dated 4/12/18, indic	nts to was ated a ent n data cated			
	rarely made decision indicated R6 experi- required extensive hygiene, toileting a assistance of 2 for assistance to eat a the facility. The M pressure relieving on the mattress in	s severely impaired, and l ons. The MDS further rienced mild depression, assitance of one for tran and dressing; extensive bed mobility; and total and move with a wheelch DS indicated R6 had a device in the wheelchair bed, due to a high risk for current pressure ulcers	nsfers, air in and or			
	6/13/18, indicated breakdown, and in area that opened u documentation ind cream when the co tremendously." Th current open areas R6's most recent u	nursing documentation of R6 had potential for skin dicated R6's coccyx had up from time to time. The icated staff used a barrie poccyx opened "which help here was no indication of S. undated/unsigned physici o check placement of	an e r os any			
Vinnesota D	epartment of Health			I		

Minneso	ota Department of He	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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GOOD S	AMARITAN SOCIETY		FIRST STREE STBROOK, MN	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	X (EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETE DATE
2 900	Continued From pa	age 8	2 900			
		of dressing) to the residen o change the Tegaderm as prevention.				
/innesota D	potential for skin im incontinence of box physical mobility re and weakness. Th R6 had a history of the right and left but to keep skin dry, us skin obs (observati to buttocks change pressure ulcers. Thad pressure reliev Rojo (specialized p wheel chair, and a another problem an having limited phys Parkinson's diseas discomfort, and his syndrome. Interve a full lift with 2 assi ambulate due to pr disease, requires of wheelchair mobility chair that staff assi assistance to repose two assistance for moving up in bed. Review of R6's Tre (TAR) indicated to to coccyx daily and prevention. The st 1/20/18. The TAR	sed 5/17/18, identified a npairment related to occas wel and bladder, decrease lated to Parkinson's disea the care plan further indicat two stage 2 pressure are uttocks. Interventions inclu- se lotion on dry skin, week ons) by nurse, and Tegad das needed for prevention he care plan also indicate ving and reducing mattress oressure reducing pad) in reclining wheelchair. In rea, R6 was identified as sical mobility related to e, right shoulder gout, story of Guillan-Barre ntions included: st for transfers, unable to ogression of Parkinson's one person assist for r. R6 has an electric reclir st to operate, and requires sition self in bed with one side to side positioning, an atment Administration Re- check placement of Tegad change as needed for wo art date for the Tegaderm for June 2018 indicated ecked every day thus far a	ed ise, ed as to ided dy erm in of d R6 s, hing s to nd cord derm bund was			

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2 900	on 6/27/18 at 10:10 ulcer on the coccys were still visible wh NA-A verified R6 u incontinence prote breakdown, and Te prevent pressure u required staff assis two person assist of from surface to sur that R6 recieved p She further stated sides to keep the r R6 was repositione when refused to la for incontinence. On 6/28/18, at 10:9 observed. A small reddish/pink wound coccyx, nor was a incontinent brief or place. NA-B stated since he'd been go further stated R6 w night shift. Registe to R6's room to ob confirmed no Tega there was redness to the resident's co applied gloves, le and returned. Afte applying gloves, th wound cleanser ar before a Tegaderm	(NA)- A stated during 0 a.m., that R6 had a x that was healed, but here the Tegaderm w sed barrier cream for ction and prevention egaderm on the cocc licers, and confirmed at with all cares. NA- was required to trans rface with a full body assive range of motion pillows were placed of esident of the coccys of every 3 hours, offly down, and regularly 50 a.m. R6's coccys of bed was identified of the coccys of bed was identified of bedding. No Tegade to bed ding. No Tegade to bed ding. No Tegade to bed ding. No Tegade to bed nurse (RN)-B was serve R6's coccys. F derm was present ar , and a pinhole sized boccys. RN-B washed I cleansed the open a tage was observed. of the room to gather r washing hands aga e area was cleansed and gauze and allowed	a pressure it areas as placed. r of skin yx daily to I R6 A said a fer R6 lift, and on daily. under R6's (, and that oaded y checked was <i>i</i> th a over R6's in R6's erm was in epositioned . NA-B o by the as called N-B nd verified open area I hands, area with a RN-B r supplies, ain and I with d to air dry				
Minnesota D	epartment of Health			μ			

Minnesota D	epartment of He	ealth					
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLI IDENTIFICATION N		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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2 900 Coi	ntinued From pa	age 10		2 900			
RN	I-B was unsure v	when R6 had last be	en				
		vas unable to determ					
		v or an existing oper					
		coccyx had not been					
		it had been a "really					
		nfirmed R6 had a his nd used Tegaderm a					
		on of open areas. R					
		e 2018, TAR with the					
		entation of daily Teg					
		ent skin breakdown.					
		3, indicated R6's cod					
		on that date for Teg					
		r, RN-B verified the checked before bre					
		applied due to "lack of					
		lity Follow Up Quest					
		surveyor which indic					
		ned at 7:35 a.m. Pro					
		6/3/18, two open are					
		n R6's buttocks area					
		e inside crease, and					
		crease. However, up confirmed there wa					
		nd related to the ope					
		8. RN-B stated all					
doc	cumentation for	pressure ulcers was					
		ical record in the use					
		A) tab under skin obs					
		ess notes, but none					
	ntified 6/3/18.	opening or the two a	ieas				
		with the director of					
		at 11:57 a.m., the DC					
		ssess and monitor p					
		et and cut in stone."					
		n the charge nurse if of skin is observed, t					
		e wound, documents					
Vinnesota Departi				ļ			1

Minneso	ta Department of He	ealth					
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GOOD S	AMARITAN SOCIETY	- WESTBROOK	149 FIRS	T STREET, B OOK, MN 56	OX 218		
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2 900	Continued From pa	age 11		2 900			
	communicates find said if RN-A was u the DON and follow DON added, "If a r medical attention, a immediately to detuin immediate, the nur orders, and faxes t she doesn't expect measure pressure document presence implement interver orders. The DON areas is completed the UDA tab, and it day, RN-A is notified and monitored on a a wound does not or a wound is composited. The wo	ntacts the provider, lings with RN-A. The inavailable, staff wo w up on the skin cor- esident needs imme a physician is inform ermine treatment. If se treats the wound the physician." The charge nurses to s- ulcers, but they need e of open skin areas to be a s	e DON uld notify neern. The ediate hed f it is not d with house DON said tage or ed to s, and house n of open titions under ed on bath asured, healed. "If I treatment, e is tacts the				
	progress notes, an observations, were 6/28/18 following th confirmed no follow identified in R6's cl identified 6/3/18. T RN-A had identified	n of skin observatio d RN weekly wound reviewed with the I ne interview. The D v up documentation hart regarding the w The DON stated she d the areas from 6/3 and of no concern, b	DON on ON was rounds thought 3/18, as not				
	unable to locate do if/when the 6/3/18 RN-A, to determine or to determine wh stated follow docur completed by nurs	wounds had been a wounds had been a they were not pres en they resolved. T mentation was supp ing when a wound v N further stated R6	cate ssessed by sure, and The DON osed to be vas				
Minnesota D	epartment of Health			μ			1

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	schedule in the car should be aware of residents are reposi- verified no reposition determine effective program, even thou breakdown. Finally documention of rep accurate due to tim	nent and repositioning re plan, and stated nu f when, and how frequesitioned. However, the pring audits were cor- eness of R6's reposition ugh R6 had a history y, the DON acknowles positioning, may not be the when NAs are rea- ty's Guidelines for Pri-	rrsing uently, e DON npleted to oning of skin ged NA oe ally busy.				
	Ulcer Practice Guid findings/changes in resident's primary of nurse. "Document notification, orders and resident respo- followprocedures have a system in p pressure ulcers wit documentation from when a complica Once a resident ex assessment should determines the sex interventions neces include the presen- pressure ulcers, ot skin conditions (ras identification of exi injury, which is skin temperature and/o to surroundings sk identified. At the ti clinician may deter consistent with tiss unrelieved pressur clinician should do	m the Wound Data Co tion or change is iden periences a pressure d take place immedia verity of injury and treasery. Documentation ce of existing Stage I- her wounds/open are shes, bruises, cysts, e sting signs of deep tis n that shows evidence r texture changes as in and should be note me of assessment, the mine an ulcer if prese- ue damage associate e. When this is the c cument the clinical ba	significant rted to the icensed provider ication should on should ing of ollection ntified. e ulcer, an tely that atment n should -IV as and or ect.), ssue e of color, compiled ed, if ne ent, is not ed with ase, the asis				
		llcer (arterial, stasis, o	diabetic)				
/innesota D	epartment of Health						

Minneso	ta Department of He	ealth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION N		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00082		B. WING		06/2	28/201 <u>8</u>
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK		T STREET, B OOK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED B LSC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	age 13		2 900			
	from a pressure ule the Wound Data C observation and m shift-to-to shift pers dressing change.	cer. It is recommend collectionreflect the anagement of wound spective and with ead At a minimum, week ecommended to prov	e nurse's ds from a ch ly				
	The director of nur- all residents at risk they are receiving to treatment/services from developing ar pressure ulcers. T designee, could co delivery of care; to services are implein pressure ulcer dev	to prevent pressure nd to promote healing the director of nursing onduct random audits ensure appropriate mented; to reduce the elopment.	uld review to assure ulcers g of g or of the care and e risk for				
	(21) days.	R CORRECTION: T	wenty-one				
21134		970 Supb. 2. Dishwas	shing;	21134			8/7/18
	must be thoroughly surfaces of utensil given sanitization t in such a manner a contamination. Cle and utensils must protects them from	ge. All utensils and of y cleaned, and food-of ls and equipment mu reatment and must l as to be protected fro eaned and sanitized be handled in a way in contamination.	contact ust be be stored om equipment that				
Ainnesota D	epartment of Health						<u> </u>

Minnesc	ta Department of He	ealth					
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	D.	(X2) MULTIPL A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00082		B. WING		06/2	8/20 <u>18</u>
NAME OF	PROVIDER OR SUPPLIER	ST	REET ADD	RESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK		STREET, B OK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21134	Continued From pa	age 14		21134			
	failed to ensure pro water pitchers and prevent bacteria fo food-borne illness.	ion and interview, the fac oper drying and storage of stainless steel milk serv rmation and potential for This deficient practice h all 25 residents residing in	of ers to had the		corrected		
Minnesota D	cook-A on 6/25/18, observations were pitchers were observations were cabinet, in an uprig an one-eighth-inch of the pitchers. Wa surface of the shell lower counter cabin stainless steel milk were layered irregu similar silver conta containers were op the containers. Dur confirmed water was stainless steel milk on the shelf surfac were stored. Cook- items used to store appropriately dry, a covered in a dry ar growth. unable to recall wh steel containers ha was likely they we meal on 6/25/18.	vation of the kitchen with at 12:39 p.m. the follow made: Two of four wate erved uncovered in a kitc pht position with approxin of water located at the b ter was also visible on th f surrounding the pitcher net in the kitchen, four of a servers with attached lic ularly on top of a full tray iners. The lids of the fou ben with water in the bott ring the observation, coo as present in the pitchers a servers, and verified the e where the water pitche A stated it was important and serve food, were and stored upside down of ea so as to inhibit bacter Cook-A en the pitchers and stair id last been used, but tho re washed after the brea	ing er hen nately pottom he s. In a f 20 ds, of r top oms of k-A s and e water ers it that or rial was pless pught it kfast				

Minneso	ta Department of H	ealth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00082		B. WING		06/2	8/201 <u>8</u>
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		_
GOOD S	AMARITAN SOCIET	- WESTBROOK		T STREET, E OOK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B LSC IDENTIFYING INFORM	SY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETE DATE
21134	and other contained drying rack located dishwasher to allow these items were r to prevent risk for During an interview stated after the dis- items were either I on they drying rack washer and allowed away. DA-B stated serve juice on sna carts at med pass with attached lids w breakfast time. DA "younger" staff got before they were of food and nutrition this and had provid drying and storage During interview of verified the serving be air-dried and no acknowledged bei staff putting the pit cupboards prior to stated, "we just tal further stated the p were used for both passes. The facility policy a and storage were SUGGESTED ME	ng items such as waters, was to place the d next to the clean end w them to air dry. DA not to be put away un contamination. W on 6/27/18 at 9:18 th washing process, eff in the wash trays on the clean side of ed to dry prior to putt the pitchers were un ck carts, and on the times. The silver co- were used to serve ro- habit a hurry and put it fry. DA-B said the difference in a hurry and put it fry. DA-B said the difference of dishes. In 6/27/18, at 9:40 a. g containers were sub of put away until dry. ng aware of issues ro- chers and milk conta- them being dry. The ked about this." The bitchers and milk conta- them being dry. The ked about this." The bitchers and milk conta- them being dry. The ked about this." The bitchers and milk conta- them being dry. The ked about this." The bitchers and milk conta- them being dry. The ked about this." The bitchers and milk conta- them being dry. The ked about this." The bitchers and milk conta- them being dry. The ked about this." The bitchers for conta- them being dry. The for meal service and milk conta- them being dry. The for mean service and milk conta- them being dry. The for mean service and milk conta- them being dry. The for mean service and milk conta- them being dry. The for mean service and milk conta- them being dry. The for mean service and milk conta- them being dry. The for mean service and milk conta- them being dry. The for mean service and milk conta- them service and milk conta- th	m on the nd of the A-A said ntil fully dry a.m., DA-B serving or placed of the dish ing them sed to medication ntainers milk at etimes the ems away rector of aware of to proper m. the DFN eposed to The DFN elated to ainers in e DFN hainers nedication	21134			
Ainnesota D	The dietary manag	per, or designee, cou cies and procedures	uld				
STATE FOR				⁶⁸⁹⁹ H	IWFS11	If continuatio	n sheet 16 of 17

Minnesota Department of Health										
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		00082		B. WING		— 06/2	8/201 <u>8</u>			
NAME OF	PROVIDER OR SUPPLIEF	1	STREET AD	DRESS, CITY, STATE, ZIP CODE						
GOOD S	AMARITAN SOCIETY	Y - WESTBROOK		T STREET, BOX 218 OOK, MN 56183						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCI CY MUST BE PRECEDED B LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETE DATE			
21134	Continued From p	age 16		21134						
	dishwashing and s educate staff rega manager, or desig periodically, to ens protocols.	storage of dishes, and rding any revisions.T nee, could perform a sure implementation OR CORRECTION: T	he dietary audits of							
Minnesota D	epartment of Health									