DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITT FE SURVEY AGE				D: J33Y Facility ID: 00082	
MEDICARE/MEDICAID PROVI NO.(L1) 245595 STATE VENDOR OR MEDICAI (L2) 017840300		3. NAME AND AD (L3) GOOD SAM (L4) 149 FIRST S (L5) WESTBROOM	ARITAN SOC STREET, BOX	CIETY - W	ESTBROOK (L6) 56183	3	 Initia Term Valid 	ination ation	2. Recertificati 4. CHOW 6. Complaint	on
5. EFFECTIVE DATE CHANGE OF (L9)	FOWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 C	CLIA	7. On-Si 8. Full S	te Visit Survey After	9. Other Complaint	
6. DATE OF SURVEY 03/8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/29/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YE	EAR ENDIN 2/31	NG DATE: (L3	35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF 34 (L37) (L38) 16. STATE SURVEY AGENCY REPORT	34 (L18) 34 (L17) OWN 5 19 SNF (L39)	B. Not in Compi Requirements ICF (L42)	nce With Equirements Based On: Coceptable POC Cocep	ım Vaivers:	And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room * Code: A (L12) 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY	AGENCY	APPROVAL		Date:	
Kathryn Serie, Unit			3/29/2016	(L19)	Kamala Fiske-Do				alist 03/29/201	16 (L20)
19. DETERMINATION OF ELIGIB 1. Facility is Eligible to 2. Facility is not Eligible	ILITY Participate	20. COM	BY HCFA RE PLIANCE WITH ITS ACT:		21. 1. Stateme 2. Ownersl 3. Both of	nt of Finar hip/Contro	ncial Solvency	(HCFA-257	*	
22. ORIGINAL DATE OF PARTICIPATION 01/01/1992	23. LTC AGREEN BEGINNING		LTC AGREEM		26. TERMINATION A VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/1	00	_	INVOLUN 05-Fail to N	Meet Health/Safety	
(L24) 25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS a of Admissions:	(L44) (L45)		03-Risk of Involuntary 04-Other Reason for Wi	Гегтіпаtіо	n	<u>OTHER</u>	Meet Agreement er Status Change	
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS					
	(L28)	00140		(L31)						
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE						

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245595

March 29, 2016

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

Dear Mr. Dejager:

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 March 22, 2016 the above facility is certified for or recommended for:

34 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kumalu Fiske Downing

Licensing and Certification Program Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered March 29, 2016

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

RE: Project Number \$5595026

Dear Mr. Dejager:

On February 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 11, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 29, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 21, 2016 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 February 11, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 22, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 11, 2016, effective March 22, 2016 and therefore remedies outlined in our letter to you dated February 26, 2016, 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,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	•		_		
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REV	'ISIT
IDENTIFICATION NUMBER	A. Building				
	B. Wing	,	,	3/29/2016	1/0
Z 10000 Y1		Y	Y2	0,-0,-0	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY	- WESTBROOK	149 FIRST STREET, BOX 218			
		WESTBROOK, MN 56183			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0279 483.20(d), 483.	Correction	ID Prefix Fo	0312 33.25(a)(3)	Correction	ID Prefix	F0329 483.25(I)		Correction
Reg. # LSC		Completed 03/22/2016	Reg. #		O3/18/2016	Reg. # LSC			O3/18/2016
ID Prefix	F0428	Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. # LSC	483.60(c)	Completed 03/18/2016	Reg. #		Completed	Reg. # LSC			Completed
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
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LSC			LSC _		-	LSC			
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Reg. # LSC		Completed	Reg. #		Completed	Reg. # LSC			Completed
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REVIEWS CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE	0.		D	DATE	<u> </u>
FOLLOW 2/11/201		COMPLETED ON		FOR ANY UNCORRECTED DEFICIENCE			IE EAGULIEVO	YES	S 🗆 NO

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_	F FACILITY SAMARITAN SOCIE	TY - WESTBROO	K		149 FIR	r ADDRESS, C ST STREET, E ROOK, MN 56	3OX 218	E, ZIP CODE		
program correcte provisio	This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments or orgram, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).									
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Reg. #		Completed	Reg. #			Completed	Reg. #		Con	npleted
LSC	K0029	03/18/2016	LSC	K0050		03/18/2016	LSC	K0052	03/1	8/2016
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GOOD	SAMARITAN SOCIE	TY - WESTBROO	K			IRST STREET, E					
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provision the sur	ed and the date such on number and the ic vey report form).			ously shown or				wn to the left o			ent on
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: J33Y

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

I	PART I - T	TO BE COMPL	LETED BY T	HE STAT	TE SURVEY	AGENCY		Facility ID: 00082
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245595 2. STATE VENDOR OR MEDICAID NO. (L2) 017840300		3. NAME AND AD (L3) GOOD SAM (L4) 149 FIRST S (L5) WESTBROO	IARITAN SOC STREET, BOX	CIETY - W		56183	4. TYPE OF ACT 1. Initial 3. Termination 5. Validation	CION: 2 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERS (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey A	9. Other fter Complaint
6. DATE OF SURVEY 02/11/2016 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	6 (L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR EN	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 34 13.Total Certified Beds 34	(L18) (L17)	X B. Not in Com	equirements e Based On:	gram	2. Tech 3. 24 F 4. 7-Da 5. Life	nnical Personnel	The Following Require 6. Scope of 7. Medical F) 8. Patient R 9. Beds/Roo (L12)	Services Limit Director oom Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 34 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY 1	MEETS	(L15)	
16. STATE SURVEY AGENCY REMARKS (I	F APPLICAI	BLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:
Lois Boerboom, HFE NE II		0	3/14/2016	(L19)	Kamala Fisk	e-Downing, E	Enforcement Spe	ecialist 03/22/2016 (L20
PART II -	TO BE C	COMPLETED E	BY HCFA RE	GIONAL	OFFICE OF	R SINGLE ST	TATE AGENCY	
DETERMINATION OF ELIGIBILITY	(L21)		IPLIANCE WITH ITS ACT:	I CIVIL	2. (cial Solvency (HCFA-2 l Interest Disclosure St :	
22. ORIGINAL DATE 23. LT	C AGREEM	IENT 24	4. LTC AGREEM	MENT	26. TERMINA	TION ACTION:		(L30)
01/01/1992	EGINNING	DATE	ENDING DAT	ΓE	VOLUNTARY 01-Merger, Clos		05-Fail	UNTARY to Meet Health/Safety to Meet Agreement
25. LTC EXTENSION DATE: 27. AI		VE SANCTIONS of Admissions:	(L25)			untary Termination	n <u>OTHE</u> F	R vider Status Change
(L27) B.	Rescind Sus	spension Date:	(L45)					
28. TERMINATION DATE:	29.	INTERMEDIARY/	CARRIER NO.		30. REMARKS			
(L28	3)	00140		(L31)				
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION	OF APPROVAL	DATE				
(L32	2)			(L33)	DETERMIN	ATION APPR	ROVAL	



Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered February 26, 2016

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

RE: Project Number \$5595026

Dear Mr. Dejager:

On February 11, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<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 a "F" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor Health Regulation Division Minnesota Department of Health Email: <u>Kathryn.serie@state.mn.us</u>

Office: (507) 476-4233Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 22, 2016, the Department of Health will impose the following remedy:

State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made

timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 11, 2016 (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 August 11, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections State Fire Marshal Division

Email: tom.linhoff@state.mn.us

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 03/08/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245595	B. WING _		02/	11/2016
	PROVIDER OR SUPPLIER	- WESTBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000			F 00	00		
	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.					
F 279 SS=D	Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 9 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS		F 27	79		3/22/16
00-2	A facility must use t	he results of the assessment and revise the resident's				
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.					
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	tdescribe the services that are ttain or maintain the resident's physical, mental, and eing as required under ervices that would otherwise 483.25 but are not provided as exercise of rights under the right to refuse treatment).				
ABORATOR)	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE

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

(X6) DATE

Electronically Signed

03/07/2016

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.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245595	B. WING		02/11/2016		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK	1	STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION		
F 279	Continued From pa	ige 1	F 279				
	by: Based on observareview the facility fareview the fareview th	tion, interview and document ailed to develop a plan of care nts (R17) reviewed for bruises ents (R35, R11) reviewed for		Preparation and execution of this response and plan of correction do constitute an admission or agreement the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan correction is prepared and/or execution solely because it is required by the provisions of Federal and State law the purposes of any allegation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with secution 7305 of the State Operations Manual F279	ent by he n of uted r. For f		
	identified a bruised area measured 1.0 weekly skin assess not include R17's be assessment also id no skin issues. Rephysicians orders in Coumadin daily (a most current plan obeing at risk for ble blood thinner. No dwhich identified into Interview with the d 2/10/16 at 8:20 a.m should have been respective.	ogress note dated 1/29/16, area on the right forearm. The cm by 4.0 cm. Review of the ment form dated 1/31/16, did ruises on the arms. The lentified the resident as having view of R17's current indicated R17 receives blood thinner). Review of the of care did not include R17 as eding/bruising nor the use of a evelopment of a plan of care erventions were listed. irrector of nursing (DON) on an confirmed R17's bruising monitored and care planned ruising related to the use of a		It is the current policy and procedur GSS – Westbrook to assess and do appropriate care plans, regarding strisks, for every resident. The care plan for R17 was updated reflect skin risks relating to anticoaguse and thin, frail skin; appropriate interventions were put in place. All residents receiving anticoagulant therapy have had their care plans reviewed and updated to reflect skir relating to anticoagulant use and the skin; appropriate interventions are inplace. The case manager has been re-editions are defined to a second to the case manager has been re-editions.	evelop kin I to gulant It n risks in, frail n		
	blood thinner.	along rolated to the use of a		regarding skin risk assessments.			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245595	B. WING		 	02/11/201		
NAME OF I	PROVIDER OR SUPPLIEF	3		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIET	Y - WESTBROOK			9 FIRST STREET, BOX 218 ESTBROOK, MN 56183			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	Rass was observed have long facial have assistant needs. Review of for Rass did not included the long facial hairs because Rass stated she was facial hairs if she have long further confirmed further confirmed resident with shave long at 9:08 a.m. confir care which include shaving/grooming	d on 2/10/16 and 2/11/16 to airs on the chin. Juarterly Minimum Data Set /16, identifies R35 as requiring ace of 1 person with grooming the most current plan of care clude the resident's grooming on 2/11/16, at 8:48 a.m. R35 not aware of her notable long se she was unable to see them. Pull be bothered by these long and known. R35 revealed the er weekly, but was unsure. Sing assistant (NA)-A on 2/11/16 ated R35's plan of care did not needs/shaving for R35 and the staff did not assist the ing. Stered nurse (RN)-A on 2/11/16 med R35 did not have a plan of ed assistance with needs. RN-A verified R17 had a requiring assistance with	i	279		es have of t for all week x QAPI acy and e re of evelop sident. ere nal r itions		
	R11 was observed 12/10/16, at 12:20 a.m. to have long upper lip and unde Review of the the Status (BIMS) doo Minimum Data Se	d on 2/9/16, at 3:24 p.m., on p.m. and on 2/11/16, at 9:44 facial hair extending across her			to facial hair, grooming, and approinterventions are in place. The case manager has been educ regarding facial hair grooming need corresponding care planning, and appropriate interventions. A weekly audit will be conducted by	oriate ated ds,		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245595	B. WING			02/-	11/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK		14	TREET ADDRESS, CITY, STATE, ZIP CODE 49 FIRST STREET, BOX 218 /ESTBROOK, MN 56183	, , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	score of 8/15. The indicated: extensive personal hygiene. Review of R11's modated 1/22/16 indic performance deficit dementia, confusio Assistance of 1 for interventions/monit addressed the groom management of factor of the personal pers	activities of daily living (ADLs) assistance required for easistance required for easistance required for easistance required for easistance required care plan ated: ADL self care related to (R/T) weakness, en. Interventions included: personal hygiene. No coring were included which eming needs related to the cial hair. If on 2/10/16, at 7:58 a.m. required extensive Ls. a.m. R11 was interviewed ence of facial hair on her upper R11 reached and rubbed the lip and chin and stated staff shave the areas for her and	F 2	279	or designee x 3 weeks, then month Audit reports will be reviewed by th committee with appropriate follow- initiated Corrected Date: March 22, 2016	e QAPI		
		ided which addressed the						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		245595	B. WING		02/11/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK	1	TREET ADDRESS, CITY, STATE, ZIP CODE 49 FIRST STREET, BOX 218 VESTBROOK, MN 56183	
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F 279 F 312 SS=D	residents. 483.25(a)(3) ADL C DEPENDENT RES A resident who is u daily living receives	Shaving/grooming of female CARE PROVIDED FOR	F 279		3/18/16
	by: Based on observative review the facility faservices for 2 of 3 representation for activities of daily. Findings include: R35 was observed have long facial hair R35's quarterly Min 1/20/16, identifies Fassistance of 1 per Review of the most did not include the when interviewed of indicated she was refacial hairs as she was attended to the state of the conce she's made at may shave her we occurred.	tion, interview and document ailed to provide grooming residents (R11, R35) reviewed valuing (ADL's). on 2/10/16 and 2/11/16 to rs on the chin. Review of imum Data Set (MDS) dated R35 as requiring extensive son with grooming needs. Current plan of care for R35 resident's grooming needs. on 2/11/16, at 8:48 a.m. R35 resident's grooming needs. on 2/11/16, at 8:48 a.m. R35 red by these long facial hairs ware. R35 revealed the staff ekly, but was unsure whether it		It is the current policy and procedure of GSS Westbrook to assess and devappropriate care plans, regarding activities of daily living, for every resident of the care plans for R35 and R11 were updated to reflect residents personal hygiene needs relating to facial hair grooming, and appropriate intervention were put in place. For all residents, the care plans have been reviewed to ensure they reflect residents personal hygiene needs related to facial hair, grooming, and appropriate interventions are in place. The case manager has been educate regarding facial hair grooming needs, corresponding care planning, and appropriate interventions.	elop lent. ns

	IENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		A. BUILD	ING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245595	B. WING			02/1	11/2016	
NAME OF PROVIDER OR SU				14	TREET ADDRESS, CITY, STATE, ZIP CODE 49 FIRST STREET, BOX 218 VESTBROOK, MN 56183	,		
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
include groofurther confiresident with linterview with at 9:08 a.m. requiring assineeds but cocare which it shaving/groof R11 was obsiz/10/16, at a.m. to have upper lip and Review of th Status (BIMS Minimum Da R11 had moscore of 8/15 indicated: expersonal hygonesis Review of R dated 1/22/1 performance dementia, cocassistance of interventions	indica ming ramed to shavi have registed to shavi have registed to shavi have registed to shave regist	ted R35's plan of care did not needs/shaving for R35 and the staff did not assist the ing. Stered nurse (RN)-A on 2/11/16 at R17 had been assessed as see with grooming/shaving ed R35 did not have a plan of assistance with needs. I on 2/9/16, at 3:24 p.m., on p.m. and on 2/11/16, at 9:44 facial hair extending across here her chin. Brief Interview for Mental umented on the annual at dated 12/31/15, indicated that a cognitive impairment with a activities of daily living (ADLs) re assistance required for cost recent/updated care plan cated: ADL self care it related to (R/T) weakness, on. Interventions included: repersonal hygiene. No toring were included which oming needs related to the	F3	112	A weekly audit will be conducted by or designee x 3 weeks, then month Audit reports will be reviewed by the committee with appropriate followinitiated. Corrected date: March 18, 2016	nly x 1. e QAPI		
NA-D indicate assistance w	ed R1	v on 2/10/16, at 7:58 a.m. 1 required extensive 0Ls. 4 a.m. R11 was interviewed						

STATEMENT OF D AND PLAN OF COI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245595	B. WING		02/	11/2016
	DER OR SUPPLIER	- WESTBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
regulip a area had she Wh lice and on I hair Wh NA- and She SS=D UNI Eac unn drug dup with indi adv sho con Bas resi who give their	and chin area. Fas on her upper I not offered to so would like to have an interviewed on sed practical not then indicated ther scheduled by the sed on a compression of the sed on a compression at the facility of have not used an these drugs upper sed on a compression at the facility of have not used an these drugs upper sed on a compression at the facility of have not used an these drugs upper sed on a compression at the facility of have not used an these drugs upper sed on the sed on a compression at the sed on	ence of facial hair on her upper R11 reached and rubbed the lip and chin and stated staff have the areas for her and ave this done. On 2/11/16, at 9:50 a.m. urse (LPN)-A observed R11 R11 should have been shaved ath day to remove the facial on 2/11/16, at 10:55 a.m. ats are checked for facial hair ney receive their weekly bath. On a.m. RN-A verified the R11 provided personal grooming cial hair. EGIMEN IS FREE FROM	F3			3/18/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		E SURVEY PLETED
		245595	B. WING _		02/-	11/2016
	PROVIDER OR SUPPLIER	- WESTBROOK		STREET ADDRESS, CITY, STATE, ZIP COI 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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	drugs receive grad behavioral interver	age 7 Ints who use antipsychotic ual dose reductions, and altions, unless clinically an effort to discontinue these	F 32	29		
	by: Based on observareview the facility to psychoactive medic (R13) reviewed for Findings include: R13's Diagnosis record included: danxiety disorder. Physician orders disprescribed Ativan (times a day (anti-adaily (antidepressare) dated 12/17 no behaviors in the resident was identic concentrating, feel and feeling down. over the past 6 mo and behaviors that during the assessing the facility of the most over the past 6 mo and behaviors that during the assessing the facility of the facility of the past 6 mo and behaviors that during the assessing the facility of the f	t current Minimum Data Set 7/15, identified R13 as having assessment period. The fied as having trouble ing tired, having little energy Review of the progress notes nths did not include any mood were identified on the MDS		It is the current policy and progress – Westbrook to ensure a drug regimens are free from a medications. R13 had an increase in her C December 22, 2015 and an inher Ativan on January 7, 2016 Pharmacist consultant visited 2016 but did not list any concrecommendations over R13's psychoactive medications. R on January 21, 2016, and phy from the visit stated, current reference reviewed and are to be without change. The progress stated R13 has tolerated increased R13 has tolera	residents' unnecessary rymbalta on ncrease in 5. January 26, erns or 13 was seen vsician's note medications continued s note also eased van at this was obtained R13's 13's care 016 to	

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245595	B. WING		02/-	11/2016
	PROVIDER OR SUPPLIER	- WESTBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329 F 428 SS=D	Interventions include symptoms of mood sad and depressed. Review of the physical evaluation of R13's medications related current dose/reduct. When interviewed condicated she become winter months but we current medications R13 was observed time. Interview with nursical 2/11/16, at 9:00 a.m. anxious about placed is pleasant and cool interview with registant 10:00 a.m. confirmedications had not continued use in the 483.60(c) DRUG RIRREGULAR, ACT.	is in mood and anxiety. ed: observe for signs and changes that include feeling. dician notes did not include an prescribed psychoactive. It to the continued need and dion. on 2/11/16, at 8:30 a.m. R13 mes weepy at times in the was unsure whether her as were helping her feel better. It to be calm and relaxed at this one assistant (NA)-A on an indicated R13 will get ement in the nursing home but perative. Itered nurse (RN)-A on 2/11/16, and R13's psychoactive of been reassessed for the past year. EGIMEN REVIEW, REPORT	F 329	psychoactive medications as well a provide thorough documentation of behaviors. All residents currently using psych medications have been evaluated unnecessary medications. Pharmacy consultant informed of the details of the F329 tag. Pharmacy consultant to continue to conduct a medication reviews with emphasis psychoactive medications and proper tand recommendations to designated personnel. Pharmacy recommendations will be reviewed monthly x 3 by behavior/reduction committee to eappropriate recommendations are related to evaluating the continued psychoactive medications. QAPI committee will review finding make recommendations. Corrected date: March 18, 2016	oactive for the monthly on vide e made I use of	3/18/16
	the attending physic	est report any irregularities to cian, and the director of reports must be acted upon.				

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			E SURVEY IPLETED		
		245595	B. WING _		02/	11/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH COROSS-REFERENCED TO THE APPROPRIEM OF THE A	OULD BE	(X5) COMPLETION DATE
F 428	Continued From pa	ge 9	F 42	28		
	by: Based on observative review the facility or identify irregularities for effectiveness of 1 of 5 residents (R1 medication. Findings include: R13's Diagnosis represerved included: deanxiety disorder. Physician orders daprescribed Ativan 0 times a day (anti-ardaily (antidepressan) Review of the most (MDS) dated 12/17, no behaviors in the resident was identificant was identificant feeling down. Fover the past 6 morand behaviors that during the assessman Review of the curreas having alteration Interventions included.	current Minimum Data Set /15, identified R13 as having assessment period. The ied as having trouble ng tired, having little energy Review of the progress notes of this did not include any mood were identified on the MDS ment period. Int plan of care identifies R13 as in mood and anxiety. Ied: observe for signs and changes that include feeling		It is the current policy and proced GSS – Westbrook to ensure redrug regimens are reviewed at monthly and that any irregulariting reported and acted on. The pharmacist has reviewed Fourrent medications, and they appropriate. All residents have been reviewed pharmacist, and any irregularities to ongoing monitoring for effect psychoactive medications were and appropriate recommendation made. Pharmacy consultant has been of the details of the F428 tag. For consultant to continue to condumedication reviews with emphapsychoactive medications and preport and recommendations to designated personnel. Review QAPI committee with appropriate recommendations. Corrected Date: March 18, 201	sidents' least once es are R13's least once es are R13's least once es are R13's least once led by les related iveness of reviewed, ons were linformed Pharmacy ct monthly sis on orovide of findings at te	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245595	B. WING _		02	/11/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK	STREET ADDRESS, CITY, STATE, ZIP COI 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	evaluation of R13's medications related current dose/reductions. Pharmacy reviews any recommendation continued need at continued she becontinued indicated she becontinued need to continue the past year and relaxed at this interview with nursical 2/11/16, at 9:00 a.m. anxious about place is pleasant and continued in the past year. When attempted to the past year and relaxed in the past year.	ician notes did not include an prescribed psychoactive d to the continued need and tion. in the past year did not include ons for an evaluation of the current dose and/or dose R35's psychoactive on 2/11/16, at 8:30 a.m. R13 mes weepy at times in the was unsure whether her we medications were helping 3 was observed to be calm time. Ing assistant (NA)-A on in. indicated R13 will get ement in the nursing home but operative. tered nurse (RN)-A on 2/11/16, rmed R13's psychoactive of been assessed for continued	F 42	,		

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PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245595 B. WING 02/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 149 FIRST STREET, BOX 218 **GOOD SAMARITAN SOCIETY - WESTBROOK** WESTBROOK, MN 56183 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on February 10, 2016. At the time of this survey, Building 01 of Good Samaritan Society Westbrook was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or (X6) DATE

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

TITLE

Facility ID: 00082

Electronically Signed

03/07/2016

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG 01 - Main Building 01		MPLETED
		245595	B. WING_		02	/10/2016
				STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	By email to: Marian.Whitney@ <mailto:marian.whitney@ 01="" 1.="" 2.="" 3.="" <mailto:angela.ka="" <mailto:marian.whitney@="" a="" actual,="" addition="" additione-story,="" and="" angela.kappenma="" basement,="" building="" co="" constructio="" construction;="" correct="" defice="" deficiency="" description="" determine="" facility="" first="" following="" for="" good="" has="" ii(222)="" in="" inf="" mus="" name="" no="" of="" one-story,="" open="" or="" oresponsible="" original="" p="" plan="" prevent="" protected="" reoccurr="" second="" smok="" spaces="" system,="" td="" the="" to="" to<="" v(111)="" was="" westbrook="" whas="" with=""><td>state.mn.us hitney@state.mn.us> and an@state.mn.us appenman@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person rrection and monitoring to rence of the deficiency. and Samaritan Society constructed as follows: ang was built in 1961, is basement, is fully fire sprinkler and determined to be of Type and the sprinkler protected and the sprinkle</td><td>K 00</td><td></td><td></td><td></td></mailto:marian.whitney@>	state.mn.us hitney@state.mn.us> and an@state.mn.us appenman@state.mn.us> DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person rrection and monitoring to rence of the deficiency. and Samaritan Society constructed as follows: ang was built in 1961, is basement, is fully fire sprinkler and determined to be of Type and the sprinkler protected and the sprinkle	K 00			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION 6 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245595	B. WING		02/	10/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	and had a census	acility has a capacity of 34 beds of 28 at time of the survey. at 42 CFR, Subpart 483.70(a) is	K 000			
K 029 SS=E	NFPA 101 LIFE S. One hour fire rate fire-rated doors) of extinguishing systiand/or 19.3.5.4 prothe approved autooption is used, the other spaces by significant doors. Doors are field-applied proted 48 inches from the permitted. 19.3. This STANDARD One hour fire rate fire-rated doors) of extinguishing systiand/or 19.3.5.4 prother approved autooption is used, the other spaces by significant doors. Doors are field-applied proteging.	d construction (with o hour or an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When omatic fire extinguishing system exareas are separated from moke resisting partitions and self-closing and non-rated or ctive plates that do not exceed to bottom of the door are 1.2.1 is not met as evidenced by: ed construction (with o hour or an approved automatic fire em in accordance with 8.4.1 otects hazardous areas. When omatic fire extinguishing system exareas are separated from moke resisting partitions and self-closing and non-rated or ctive plates that do not exceed to bottom of the door are	K 029	Preparation and execution of response and plan of correctic constitute an admission or ag the provider of the truth of the alleged or conclusions set for statement of deficiencies. The correction is prepared and/or solely because it is required be provisions of Federal and Star K29	on does not reement by facts the in the eplan of executed by the	3/18/16
	between 10:00 AM during the inspect discrepancies with 1.) Oxygen storag	spection on February 10, 2016 If and 12:30 PM, observation ion revealed the following hazardous Areas: e room door did not latch into on closing and the door had a		It is the current policy and pro GSS Westbrook to maintain so that it is in compliance with Code standards and regulation. 1. A new door handle was in the oxygen room door so that into the door frame upon clos the door penetration was filled.	n the facility n Life Safety ons. nstalled on it latches ing. Also,	.4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED				
		245595	B. WING	_		02/	10/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK	1.	1	STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 NESTBROOK, MN 56183		li .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029	penetration above to 2.) Utility Room in to latch into the door of 3.) Mechanical Room closing device instance 4.) Electrical Room closing device reparts.) Boiler Room door rated and has a door the door frame. NOTE: All Hazardo to ensure compliance	he door handle. he Service Hallway did not rame upon door closing. m-200 Wing, needs a self led. -200 Wing needs the self door ired. or does not self close, is not or latch that will not latch into us Areas need to be checked ce. ctices were observed by the	K	029	fireproof caulk and a cover placed the site. Work was completed on 02/24/2016. 2. The latch on the utility room do adjusted so that the door latches in door frame upon closing. Work was completed on 02/24/2016. 3. A new self-closing device was installed on the mechanical room of 200 wing. Work was completed on 02/19/2016. 4. A new self-closing device was installed on the electrical room door wing. Work was completed on 02/19/2016. 5. Bids are being obtained for an door and self-closing device for the room so that it complies with LSC standards and regulations. 6. Bids are being obtained for wo done on the pass-thru window from kitchen dish room into the hallway	oor was not the as	
K 050 SS=D		FETY CODE STANDARD	ΚŒ)50	it complies with LSC standards and regulations.		3/18/16
	signal and simulation conditions. Fire drill times under varying on each shift. The sand is aware that drawtine. Responsible conducting drills is a	e transmission of a fire alarm on of emergency fire is are held at unexpected conditions, at least quarterly staff is familiar with procedures fills are part of established lity for planning and assigned only to competent calified to exercise leadership.				÷	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245595	B. WING		02/	10/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK		STREET ADDRESS, CITY, STATE, ZIP OF 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183	CODE		
(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 ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
K 050	6:00 AM a coded a instead of audible at 18.7.1.2, 19.7.1.2. This STANDARD is Fire drills include the signal and simulation conditions. Fire drill times under varying on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are query where drills are consistent and the same are the same and the same are the same are s	nducted between 9:00 PM and nnouncement may be used alarms. Is not met as evidenced by: the transmission of a fire alarm on of emergency fire alarm of emergency fire alarms.	ΚO	K50 It is the current policy and pGSS – Westbrook to conduvarying times on each shift. Staff members were educa requirement to conduct fire varying times on each shift conducted monthly to ensu conducted at varying times	ted as to the drills at ted as to the drills at Audits will be re fire drills are		
K 052 SS=E	2016 between 10:0 documentation reversity (11pm-7am) fire drivarying times. 1st of quarter-03:15 hrs, 3 quarter-03:00hrs. This deficient pract Facility Maintenanc NFPA 101 LIFE SA A fire alarm system be, tested, and main NFPA 70 National E National Fire Alarm available. The system	tion review on February 10, 0 AM and 12:30 PM, fire drill ealed that the night shift lls were not conducted during juarter-0300hrs, 2nd Brd quarter 23:15 hrs and 4th dice was observed by the e Director. FETY CODE STANDARD required for life safety shall intained in accordance with Electric Code and NFPA 72 Code and records kept readily em shall have an approved esting program complying with	K 0	52		3/18/16	

CENTER	45 FUR MEDICAR	E & MEDICAID SERVICES				MR NO.	0938-038
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
		245595	B. WING			02/1	10/2016
	PROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 19 FIRST STREET, BOX 218 /ESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
K 052	9.6.1.4, 9.6.1.7, This STANDARD A fire alarm system be, tested, and man NFPA 70 National National Fire Alarm readily available. Tapproved mainten complying with approved mainten for and 72. 9.6.1.4 FINDINGS INCLU Documentation reannual fire alarm in 02/04/2015.	is not met as evidenced by: m required for life safety shall aintained in accordance with Electric Code and NFPA 72 in Code and records kept The system shall have an ance and testing program plicable requirement of NFPA 1, 9.6.1.7. DE: view indicated that the last inspection was conducted on the strice was observed by the	K	052	It is the current policy and procedu GSS – Westbrook to have the fire inspected annually by a certified fit inspection contractor. The contractor was contacted and advised that their most recent fire inspection had been conducted outhe 12-month LSC requirement. Toontractor has changed the inspected schedule so that the fire alarms with inspected prior to the end of the 12 LSC requirement.	alarms re alarm alarm itside of the ction II be	

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	E CONSTRUCTION 03 - 2007 ADDITION		TE SURVEY MPLETED
		245595	B. WING		02	/10/2016
	PROVIDER OR SUPPLIER	- WESTBROOK	14	FREET ADDRESS, CITY, STATE, ZIP CO 19 FIRST STREET, BOX 218 /ESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 000			
	FIRE SAFETY					
	Minnesota Departm Fire Marshal Division the time of this survival samaritan Society be in substantial correquirements for partial Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 18 New Heat	articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), ealth Care Occupancies. THE PLAN OF R THE FIRE SAFETY				
	Health Care Fire In State Fire Marshal 445 Minnesota Stre St. Paul, MN 55101	Division eet, Suite 145				
	Angela.Kappenmar	itney@state.mn.us> and		EDO		
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:		EPO	6	
!	A description of value to correct the deficition.	what has been, or will be, done				

03/07/2016

Electronically Signed

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2007 ADDITION		(X3) DATE SURVEY COMPLETED		
		245595	B. WING		02/10/2016		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	Continued From pa	nge 1	K 000				
	2. The actual, or proposed, completion date.						
		r title of the person rection and monitoring to ence of the deficiency.	٩				
	Westbrook include consisting of a new offices. In 2011, th remodeled. These no basement, are f	d Samaritan Society s a 2007 building addition, main entrance, lobby and e dietary department was fully additions are one-story, have ully sprinklered and were f Type V(111) construction.	a	15			
	system, with smoke in spaces open to t monitored for autor notification. The fac	omplete automatic fire alarm e detection in the corridors and he corridors, which is matic fire department cility has a capacity of 34 beds of 28 at time of the survey.					
K 029	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 029			3/18/16	
SS=E	with 8.4. The areas hour fire-rated barr door, without windo Doors shall be self-accordance with 7. protected by a sprin with 9.7, 18.3.2.1, 2						
	One hour fire rated fire-rated doors) or extinguishing syste and/or 18.3.5.4 pro	s not met as evidenced by: d construction (with o hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system		Preparation and execution of t response and plan of correction constitute an admission or agre the provider of the truth of the f alleged or conclusions set forth	n does not eement by acts		

CENTE	KS FUR MEDICARI	E & MEDICAID SERVICES				IVID INO.	0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2007 ADDITION			(X3) DATE SURVEY COMPLETED	
		245595	B. WING		s	02/1	0/2016	
	PROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 49 FIRST STREET, BOX 218 VESTBROOK, MN 56183			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE	
K 029	other spaces by sr doors. Doors are field-applied protect 48 inches from the permitted. 18.3. FINDINGS INCLU During Facility Institute the inspection of t	areas are separated from moke resisting partitions and self-closing and non-rated or ctive plates that do not exceed a bottom of the door are 2.1 DE: pection on February 10, 2016 I and 12:30 PM, observation on revealed the following a Hazardous Area: dow from Kitchen Dish Room not close upon fire alarm of held open by a fusible link. Dus Areas need to be checked noce. actices were observed by the	KO	029	statement of deficiencies. The pla correction is prepared and/or exect solely because it is required by the provisions of Federal and State law K29 It is the current policy and procedured GSS Westbrook to maintain the so that it is in compliance with Life Code standards and regulations. 1. A new door handle was install the oxygen room door so that it late into the door frame upon closing. The door penetration was filled with fireproof caulk and a cover placed the site. Work was completed on 02/24/2016. 2. The latch on the utility room do adjusted so that the door latches in door frame upon closing. Work was completed on 02/24/2016. 3. A new self-closing device was installed on the mechanical room of 200 wing. Work was completed on 02/19/2016. 4. A new self-closing device was installed on the electrical room door wing. Work was completed on 02/19/2016. 5. Bids are being obtained for a redoor and self-closing device for the room so that it complies with LSC standards and regulations.	uted v. re of facility Safety ed on ches Also, nover oor was nto the as		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2007 ADDITION		(X3) DATE SURVEY COMPLETED 02/10/2016		
		245595	B. WING				
	PROVIDER OR SUPPLIER	- WESTBROOK		14	FREET ADDRESS, CITY, STATE, ZIP CODE 19 FIRST STREET, BOX 218 FESTBROOK, MN 56183		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE
K 029	Continued From page 3		KO	29	6. Bids are being obtained for work to be done on the pass-thru window from the kitchen dish room into the hallway so that it complies with LSC standards and regulations.		
K 050 SS=D	Fire drills include the signal and simulatic conditions. Fire drill times under varying on each shift. The and is aware that droutine. Responsible conducting drills is persons who are quality where drills are considered and instead of audible at 18.7.1.2, 19.7.1.2. This STANDARD is Fire drills include the signal and simulatic conditions. Fire drills include the signal and simulating on each shift. The sand is aware that droutine. Responsible conducting drills is persons who are quality where drills are conditions. Fire drills are conditions.	s not met as evidenced by: he transmission of a fire alarm on of emergency fire ls are held at unexpected g conditions, at least quarterly staff is familiar with procedures rills are part of established ility for planning and assigned only to competent ualified to exercise leadership. nducted between 9:00 PM and nnouncement may be used alarms. DE:	KO	950	K50 It is the current policy and procedur GSS – Westbrook to conduct fire d varying times on each shift. Staff members were educated as to requirement to conduct fire drills at varying times on each shift. Audits conducted monthly to ensure fire driconducted at varying times on each	o the will be rills are	3/18/16
		tion review on February 10, 0 AM and 12:30 PM,fire drill					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245595			, ,	PLE CONSTRUCTION G 03 - 2007 ADDITION		SURVEY PLETED
		245595	B. WING		02/	10/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK		STREET ADDRESS, CITY, STATE, ZIP CO 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE
K 050 K 052 SS=E	(11pm-7am) fire drivarying times. 1st of quarter-03:15 hrs, quarter-03:00hrs. This deficient pract Facility Maintenance NFPA 101 LIFE SAAA fire alarm system be, tested, and maintenance and to applicable requiren 9.6.1.4, 9.6.1.7, This STANDARD in A fire alarm system be, tested, and maintenance and to applicable requiren 9.6.1.4, 9.6.1.7, This STANDARD in A fire alarm system be, tested, and maintenance and to applicable requiren 9.6.1.4, 9.6.1.7, This STANDARD in A fire alarm system be, tested, and maintenance and to approve distribution of the provided maintenance and the provided mainten	ealed that the night shift ills were not conducted during quarter-0300hrs, 2nd 3rd quarter 23:15 hrs and 4th ice was observed by the se Director. IFETY CODE STANDARD required for life safety shall intained in accordance with Electric Code and NFPA 72 I Code and records kept readily em shall have an approved esting program complying with ment of NFPA70 and 72. Is not met as evidenced by: In required for life safety shall intained in accordance with Electric Code and NFPA 72 I Code and records kept he system shall have an ance and testing program licable requirement of NFPA 9.6.1.7. DE: iew indicated that the last ispection was conducted on ice was observed by the	K 05		he fire alarms ified fire alarm ed and nt fire alarm sted outside of ent. The inspection rms will be	3/18/16



Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted February 26, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5595026

Dear Mr. Dejager:

The above facility was surveyed on February 9, 2016 through February 11, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 Kathryn Serie, Unit Supervisor at (507) 476-4233.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Health Regulation Division

Kumala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	DED: '			3) DATE SURVEY COMPLETED
		00082	B. W	ING		02/11/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS			
GOOD S	AMARITAN SOCIETY	- WESTBROOK	149 FIRST STE WESTBROOK,	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
2 000	Initial Comments		2 0	00		
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDI	ĒR			
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber	hether a violation has	ssued on, it is cited violation dance rule of been ag below. re to dered upon ule will the item			
	that may result from orders provided tha the Department with	hearing on any asses n non-compliance with it a written request is i hin 15 days of receipt ent for non-compliance	these nade to of a			
Minnesota D	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the election	nt with ofinfo/inf		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal soft Tag numbers have been assigned to Minnesota state statutes/rules for Nu Homes.	
		ER/SUPPLIER REPRESENT	ATIVE'S SIGNATUF	RE	TITLE	(X6) DATE

Electronically Signed 03/07/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE (X6) MULT			(X3) DATE SURVEY COMPLETED		
		00082	B. WING		02/11/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WESTEROOK	T STREET, E OOK, MN 56		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE COMPLETE
2 000	delineated on the at Department of Heat you electronically. Is necessary for State enter the word "context. You must then State licensure product completion date, the corrected prior to elements of Minnesota Department's stand the following context of the State Licensing federal software. The assigned to Minnesota Department's state Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned to Minnesota Department of the State Licensing federal software. The assigned tag is not column entitled "ID statute/rule out of context of the State of the "Tour or order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Corplease DISREGA FOURTH COLUMN "PROVIDER'S PLA"	ttached Minnesota Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the ment of Health. Bebruary 11, 2016, surveyors of taff, visited the above provider correction orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. The alth is documenting Correction Orders using ag numbers have been ota state statutes/rules for umber appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the mis column also includes the m violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection. RD THE HEADING OF THE	2 000	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. To Column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Method Correction and the Time Period Following the Sumfindings are the Suggested Method Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SUBMIT A PLAN OF CORRECTI	Tag." I the Itute/rule Iies" Iply" Inis Is which I after the Is veyors I of I or

Minnesota Department of Health

STATE FORM 5899 J33Y11 If continuation sheet 2 of 15

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00082	B. WING		02/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK	STREET, B OOK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			3/22/16
	comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The con must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's m goals for medical, nursing, vchosocial needs that are apprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).				
	by: Based on observati review the facility fa for for 1 of 3 reside	ent is not met as evidenced on, interview and document alled to develop a plan of care nts (R17) reviewed for bruises ents (R35, R11) reviewed for ing (ADL's).		Corrected		
	Findings include:					
	on 2/10/16, at 10:08 had a 50 cent size and a 25 cent size Both bruises were conterviewed during	s on 2/9/16, at 3:00 p.m. and 8 a.m. it was noted that R17 bruise on the inner right arm bruise on the inner left arm. dark purplish in color. When the observed times, R17 she ese bruises nor how she				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		00082	B. WING		02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- WESTRROOK	T STREET, B			
		WESTBR	OOK, MN 56		1011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 3	2 560			
	identified a bruised area measured 1.0 weekly skin assess not include R17's bruises. Resphysicians orders in Coumadin daily (a bruise current plan obeing at risk for bleeblood thinner. No downich identified interview with the di 2/10/16 at 8:20 a.m should have been in	ogress note dated 1/29/16, area on the right forearm. The cm by 4.0 cm. Review of the ment form dated 1/31/16, did ruises on the arms. The entified the resident as having view of R17's current adicated R17 receives blood thinner). Review of the f care did not include R17 as eding/bruising nor the use of a evelopment of a plan of care erventions were listed. irrector of nursing (DON) on, confirmed R17's bruising nonitored and care planned ruising related to the use of a				
	R35 was observed have long facial hai	on 2/10/16 and 2/11/16 to rs on the chin.				
	(MDS) dated 1/20/1 extensive assistance needs. Review of the	arterly Minimum Data Set 6, identifies R35 as requiring se of 1 person with grooming ne most current plan of care ude the resident's grooming				
	indicated she was r facial hairs because R35 stated she wou facial hairs if she ha staff may shave her Interview with nursin at 9:07 a.m. indicate	on 2/11/16, at 8:48 a.m. R35 not aware of her notable long e she was unable to see them. ald be bothered by these long ad known. R35 revealed the r weekly, but was unsure. Ing assistant (NA)-A on 2/11/16 and R35's plan of care did not eeds/shaving for R35 and				

Minnesota Department of Health

STATE FORM J33Y11 If continuation sheet 4 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SO COMPLETED CONSTRUCTION (X3) DATE SO COMPLETED CONSTRUCTION (X4) DATE SO COMPLETED CONSTRUCTION (X5) DATE SO COMPLETED CONSTRUCTION (X6) DATE SO COMPLETED CONSTRUCTION (X7) DATE SO COMPLETED CONSTRUCTION	
00082 B. WING 02/1	1/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD SAMARITAN SOCIETY - WESTBROOK 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 560 Continued From page 4 further confirmed the staff did not assist the resident with shaving. Interview with registered nurse (RN)-A on 2/11/16 at 9:08 a.m. confirmed R35 did not have a plan of care which included assistance with shaving/grooming needs. RN-A verified R17 had been assessed as requiring assistance with grooming/shaving needs. R11 was observed on 2/9/16, at 3:24 p.m., on 12/10/16, at 12:20 p.m. and on 2/11/16, at 9:44 a.m. to have long facial hair extending across her upper lip and under her chin. Review of the the Brief Interview for Mental Status (BIMS) documented on the annual Minimum Data Set dated 12/31/15, indicated that R11 had moderate cognitive impairment with a score of 8/15. The activities of daily living (ADLs) indicated: extensive assistance required for personal hygiene. Review of R11's most recent/updated care plan dated 1/22/16 indicated: ADL self care performance deficit related to (R/T) weakness, dementia, confusion. Interventions included: Assistance of 1 for personal hygiene. No interventions/monitoring were included which addressed the grooming needs related to the management of facial hair. During an interview on 2/10/16, at 7:58 a.m. NA-D indicated R11 required extensive assistance with ADLs. On 2/11/16, at 9:44 a.m. R11 was interviewed regarding the presence of facial hair on her upper	

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 20.23.110.			
		00082	B. WING		02/1	1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK	FSTREET, E OOK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 5	2 560			
	had not offered to s she would like to ha	shave the areas for her and ave this done.				
	licensed practical n and then indicated	on 2/11/16, at 9:50 a.m. urse (LPN)-A observed R11 R11 should have been shaved ath day to remove the facial				
	NA-B stated reside	on 2/11/16, at 10:55 a.m. nts are checked for facial hair hey receive their weekly bath.				
	plan did not include	0 a.m. RN-A verified the care interventions for personal facial hair and should have.				
		ided which addressed the shaving/grooming of female				
	Director of Nursing develop, review and procedures to ensu and reflect each res The DON or design appropriate staff on	THOD OF CORRECTION: The (DON) or designee could d/or revise policies and are care plans are developed sidents current care needs. The could educate all a the policies/procedures, and any system to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
2 850	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 D Adequate and re; Shaving	2 850			3/18/16
		or determining adequate and criteria for determining				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 6 of 15 J33Y11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00082	B. WING		02/1	1/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTRROOK 149 FIRS	DDRESS, CITY, S T STREET, E OOK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 850	adequate and prope D. Assistance of all residents as reand well-groomed. This MN Requirements by: Based on observation	er care include: with or supervision of shaving necessary to keep them clean ent is not met as evidenced on, interview and document	2 850	Corrected		
	services for 2 of 3 r for activities of daily Findings include: R35 was observed have long facial hai R35's quarterly Min 1/20/16, identifies F assistance of 1 pers	ciled to provide grooming esidents (R11, R35) reviewed valuing (ADL's). on 2/10/16 and 2/11/16 to rs on the chin. Review of imum Data Set (MDS) dated R35 as requiring extensive son with grooming needs. current plan of care for R35				
	When interviewed of indicated she was in facial hairs as she was stated she is bother once she's made as may shave her wee occurred.	resident's grooming needs. on 2/11/16, at 8:48 a.m. R35 not aware of her notable long was unable to see them. R35 red by these long facial hairs ware. R35 revealed the staff ikly, but was unsure whether it				
	at 9:07 a.m. indicate include grooming not further confirmed the resident with shaving Interview with registrat 9:08 a.m. verified	ed R35's plan of care did not eeds/shaving for R35 and le staff did not assist the				

Minnesota Department of Health

STATE FORM 5899 J33Y11 If continuation sheet 7 of 15

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00082	B. WING		02/1	1/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WESTBROOK	r Street, B OOK, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 850	Continued From pa	ge 7	2 850				
	needs but confirme care which included shaving/grooming r						
	12/10/16, at 12:20	on 2/9/16, at 3:24 p.m., on p.m. and on 2/11/16, at 9:44 acial hair extending across her her chin.					
	Status (BIMS) docu Minimum Data Set R11 had moderate score of 8/15. The	Brief Interview for Mental umented on the annual dated 12/31/15, indicated that cognitive impairment with a activities of daily living (ADLs) assistance required for					
	dated 1/22/16 indic performance deficit dementia, confusio Assistance of 1 for interventions/monit	ost recent/updated care plan ated: ADL self care related to (R/T) weakness, n. Interventions included: personal hygiene. No oring were included which oming needs related to the cial hair.					
		on 2/10/16, at 7:58 a.m. I required extensive Ls.					
	regarding the prese lip and chin area. F areas on her upper	a.m. R11 was interviewed ence of facial hair on her upper R11 reached and rubbed the lip and chin and stated staff shave the areas for her and ave this done.					
	licensed practical n	on 2/11/16, at 9:50 a.m. urse (LPN)-A observed R11 R11 should have been shaved					

Minnesota Department of Health

STATE FORM J33Y11 If continuation sheet 8 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP		SURVEY LETED	
			A. BUILDING.			
		00082	B. WING		02/1	1/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTRROOK	r Street, B OOK, MN 56			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 850	Continued From pa	ige 8	2 850			
	on her scheduled b hairs.	ath day to remove the facial				
	NA-B stated reside	on 2/11/16, at 10:55 a.m. nts are checked for facial hair hey receive their weekly bath.				
	On 2/11/16, at 11:30 a.m. RN-A verified the R11 should have been provided personal grooming needs related to facial hair.					
	The director of nurs responsible for med residents the need clean and facial ha woman had identific Routine audits coul appropriate groomi	THOD OF CORRECTION: sing could in-service staff eting personal grooming for to keep nails trimmed and ir for women trimmed if the ed this as important to them. If the conducted to ensure the ng has been provided and the ported to the quality assurance				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gene	Subp.1 ABCD Unnecessary ral	21535			3/18/16
	must be free from a unnecessary drug i A. in excessive therapy; B. for excessive C. without adea D. in the prese which indicate the a discontinued.	al. A resident's drug regimen unnecessary drugs. An s any drug when used: e dose, including duplicate drug re duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in				

Minnesota Department of Health

STATE FORM 6899 J33Y11 If continuation sheet 9 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00082	B. WING		02/1	1/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02/1	1/2010	
GOODS	AMARITAN SOCIETY	149 FIRST	STREET, B	,			
	AWARITAN SOCIETY	WESTBROOK	OOK, MN 56	5183			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21535	part 4658.1310, the with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fade Department of Health Care Finance This standard is included available through the system and the State subject to frequent This MN Requirement by: Based on observation review the facility to psychoactive medic (R13) reviewed for Findings include: R13's Diagnosis regrecord included: deanxiety disorder. Physician orders daprescribed Ativan Otimes a day (anti-ardaily (antidepressan Review of the most (MDS) dated 12/17 no behaviors in the resident was identificant feeling down. Fover the past 6 more days and the past 6 more designed and feeling down. Fover the past 6 more days are the past 6 more designed and feeling down. Fover the past 6 more days are the past 6 more designed and feeling down. Fover the past 6 more days are the past 6 more	e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the Ith and Human Services, sing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not change. The entire is not met as evidenced on, interview and document of evaluate the continued use of cations for 1 of 5 residents unnecessary medication. The entire is not met as evidenced on the medical expressive episodes and atted 2/16, indicated R13 was 25 milligrams (mg) three exitety) and Cymbalta 40 mg	21535	Corrected			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00082	B. WING		02/1	1/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTRROOK	T STREET, E OOK, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 10	21535			
	during the assessm	ent period.				
	as having alteration Interventions includ symptoms of mood sad and depressed Review of the physi	cian notes did not include an				
		prescribed psychoactive to the continued need and ion.				
	indicated she becor winter months but w current medications	on 2/11/16, at 8:30 a.m. R13 mes weepy at times in the was unsure whether her were helping her feel better. to be calm and relaxed at this				
	2/11/16, at 9:00 a.m	ng assistant (NA)-A on n. indicated R13 will get ement in the nursing home but perative.				
	at 10:00 a.m. confir	tered nurse (RN)-A on 2/11/16, med R13's psychoactive It been reassessed for E past year.				
	The DON or admini procedures, educat residents drug regir	THOD FOR CORRECTION: Istrator could establish e staff and audit to ensure that men is free of irregularities and appropriate monitoring is				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00082	B. WING		02/1	1/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK 149 FIRS	DDRESS, CITY, STREET, E			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 11	21540			
21540	MN Rule 4658.1315 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			3/18/16
	monitor each reside unnecessary drug to home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medical director is a the medical director is a the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician does not the attending physician does not the order and if the change the order, the attending physician does not the dualit (QAA) committee rethe attending physician does not the attending physician does not the order and if the change the order, the attending physician does not the attending physician does not the order and if the change the order and if the change the attending physician does not the order and if the change the order and if the or	g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nut's quality of life is being the pharmacist must refer the eal director for review if the not the attending physician. If or determines that the attending have adequate justification for attending physician does not the matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter				
	by: Based on observati review the facility co identify irregularities for effectiveness of	ent is not met as evidenced on, interview and document onsulting pharmacist failed to a related to ongoing monitoring psychoactive medications for 3) reviewed for unnecessary	1	Corrected		
	Findings include:					
	R13's Diagnosis rep	port obtained in the medical				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED		
00082		B. WING	B. WING		02/11/2016			
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE				
GOOD SAMARITAN SOCIETY - WESTBROOK 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
21540	Continued From page 12		21540					
	record included: de anxiety disorder.	epressive episodes and						
	prescribed Ativan 0	ated 2/16, indicated R13 was .25 milligrams (mg) three nxiety) and Cymbalta 40 mg nt).						
	(MDS) dated 12/17 no behaviors in the resident was identificoncentrating, feeli and feeling down. F over the past 6 more	c current Minimum Data Set /15, identified R13 as having assessment period. The fied as having trouble ng tired, having little energy Review of the progress notes of the did not include any mood were identified on the MDS nent period.						
	as having alteration Interventions include	ent plan of care identifies R13 as in mood and anxiety. Ided: observe for signs and changes that include feeling l.						
	evaluation of R13's	ician notes did not include an prescribed psychoactive d to the continued need and tion.						
	any recommendation continued need at o	in the past year did not include ons for an evaluation of the current dose and/or dose o R35's psychoactive						
	indicated she beco- winter months, but current psychoactiv	on 2/11/16, at 8:30 a.m. R13 mes weepy at times in the was unsure whether her we medications were helping 3 was observed to be calm						

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STATE FORM 5899 J33Y11 If continuation sheet 13 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
			A. BOILDING.				
00082		B. WING		02/11/2016			
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - WESTBROOK 149 FIRST STREET, BOX 218 WESTBROOK, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21540	Continued From page 13		21540				
	and relaxed at this	time.					
	2/11/16, at 9:00 a.n anxious about place is pleasant and cool Interview with regis	ng assistant (NA)-A on n. indicated R13 will get ement in the nursing home but operative. tered nurse (RN)-A on 2/11/16, rmed R13's psychoactive					
	medications had no use in the past year	ot been assessed for continued r.					
		contact the facility consulting ne, a return call did not occur.					
	The administrator, consulting pharmac policies and proced medication usage. educated as neces pharmacist's review with the pharmacist	THOD FOR CORRECTION: director of nursing (DON) and cist could review and revise dures for proper monitoring of Nursing staff could be sary to the importance of the v. The DON or designee, along t, could audit medication ar basis to ensure compliance.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21915	MN St. Statute 144 Residents of HC Fa	.651 Subd. 27 Patients & ac.Bill of Rights	21915			3/18/16	
	their families shall he maintain, and partice family councils. Eat assistance and spartice meetings shall be a visitors attending or	ry councils. Residents and nave the right to organize, cipate in resident advisory and ach facility shall provide ace for meetings. Council afforded privacy, with staff or any upon the council's erson shall be designated the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
		00082	B. WING		02/1	1/2016	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	02/1	1/2010	
GOOD S	GOOD SAMARITAN SOCIETY - WESTBROOK 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE	
21915	responsibility of proresponding to writte council meetings. It is shall be encourage regarding facility por This MN Requirements: Based on interview organize a family cobasis. This had the resident families with Findings include: When interviewed of social services desifacility did not have SSD further stated families in 2014 relationary family council. SSD had not been sent to SUGGESTED MET administrator or designed and inistrator or her monitoring systems to initiate the family	oviding this assistance and en requests which result from Resident and family councils of to make recommendations olicies. ent is not met as evidenced of the facility failed to attempt to council on at least an annual potential to affect all 23 of the reside in the facility. on 2/10/16, at 8:04 a.m. the ignee (SSD) confirmed the an existing family council. last sending out a letter to ated to interest in forming a D confirmed a letter of interest to families in 2015. THOD OF CORRECTION: The signee could ensure attempts on a family council. The r designee could develop is to ensure attempts are made	21915	Corrected			