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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J33Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00082

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/29/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 03/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

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 S5595026

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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245595 Y1	A. Building B. Wing Y2	3/29/2016 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0312	Correction	ID Prefix F0329	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(l)	Completed
LSC	03/22/2016	LSC	03/18/2016	LSC	03/18/2016
ID Prefix F0428	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/18/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	03/29/2016	03048	03/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
2/11/2016	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245595	A. Building 01 - MAIN BUILDING 01 B. Wing	3/21/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 03/18/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 03/29/2016	SIGNATURE OF SURVEYOR 35482	DATE 03/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/10/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245595	A. Building 03 - 2007 ADDITION B. Wing	3/21/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 03/18/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 03/29/2016	SIGNATURE OF SURVEYOR 35482	DATE 03/21/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/10/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: J33Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00082

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/11/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 03/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00140 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 26, 2016

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

RE: Project Number S5595026

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
Email: Kathryn.serie@state.mn.us
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
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Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING _____ B. WING _____	02/11/2016

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		3/22/16

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

Electronically Signed | 03/07/2016

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care for for 1 of 3 residents (R17) reviewed for bruises and for 2 of 3 residents (R35, R11) reviewed for activities of daily living (ADL's). Findings include: During observations on 2/9/16, at 3:00 p.m. and on 2/10/16, at 10:08 a.m. it was noted that R17 had a 50 cent size bruise on the inner right arm and a 25 cent size bruise on the inner left arm. Both bruises were dark purplish in color. When interviewed during the observed times, R17 she was unaware of these bruises nor how she obtained them. Review of R17's progress note dated 1/29/16, identified a bruised area on the right forearm. The area measured 1.0 cm by 4.0 cm. Review of the weekly skin assessment form dated 1/31/16, did not include R17's bruises on the arms. The assessment also identified the resident as having no skin issues. Review of R17's current physicians orders indicated R17 receives Coumadin daily (a blood thinner). Review of the most current plan of care did not include R17 as being at risk for bleeding/bruising nor the use of a blood thinner. No development of a plan of care which identified interventions were listed. Interview with the director of nursing (DON) on 2/10/16 at 8:20 a.m., confirmed R17's bruising should have been monitored and care planned due to her risk of bruising related to the use of a blood thinner.	F 279	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. F279 It is the current policy and procedure of GSS – Westbrook to assess and develop appropriate care plans, regarding skin risks, for every resident. The care plan for R17 was updated to reflect skin risks relating to anticoagulant use 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 skin risks relating to anticoagulant use and thin, frail skin; appropriate interventions are in place. The case manager has been re-educated regarding skin risk assessments,	

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F 279	Continued From page 2 R35 was observed on 2/10/16 and 2/11/16 to have long facial hairs on the chin. Review of R35's quarterly Minimum Data Set (MDS) dated 1/20/16, identifies R35 as requiring extensive assistance of 1 person with grooming needs. Review of the most current plan of care for R35 did not include the resident's grooming needs. When interviewed on 2/11/16, at 8:48 a.m. R35 indicated she was not aware of her notable long facial hairs because she was unable to see them. R35 stated she would be bothered by these long facial hairs if she had known. R35 revealed the staff may shave her weekly, but was unsure. Interview with nursing assistant (NA)-A on 2/11/16 at 9:07 a.m. indicated R35's plan of care did not include grooming needs/shaving for R35 and 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	F 279	corresponding care planning, and appropriate interventions. All nurses have been educated on the importance of identifying residents at skin risk r/t anticoagulation . An audit of skin observation UDA's for all residents will be conducted 1x per week x 3 weeks, then monthly times 2 by QAPI Coordinator or designee for accuracy and completeness. Audit reports will be reviewed by QAPI committee with recommendations made. Corrected date: March 22, 2016 It is the current policy and procedure of GSS – Westbrook to assess and develop appropriate care plans, regarding activities of daily living, for every resident. The care plans for R35 and R11 were updated to reflect residents' personal hygiene needs relating to facial hair grooming, and appropriate interventions 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 educated regarding facial hair grooming needs, corresponding care planning, and appropriate interventions. A weekly audit will be conducted by DNS	

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F 279	Continued From page 3 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 lip and chin area. R11 reached and rubbed the areas on her upper lip and chin and stated staff had not offered to shave the areas for her and she would like to have this done. When interviewed on 2/11/16, at 9:50 a.m. licensed practical nurse (LPN)-A observed R11 and then indicated R11 should have been shaved on her scheduled bath day to remove the facial hairs. When interviewed on 2/11/16, at 10:55 a.m. NA-B stated residents are checked for facial hair and shaved when they receive their weekly bath. On 2/11/16, at 11:30 a.m. RN-A verified the care plan did not include interventions for personal grooming related to facial hair and should have. No policy was provided which addressed the	F 279	or designee x 3 weeks, then monthly x 1. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated Corrected Date: March 22, 2016	

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F 279	Continued From page 4 need for providing shaving/grooming of female residents.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services for 2 of 3 residents (R11, R35) reviewed for activities of daily living (ADL's). Findings include: R35 was observed on 2/10/16 and 2/11/16 to have long facial hairs on the chin. Review of R35's quarterly Minimum Data Set (MDS) dated 1/20/16, identifies R35 as requiring extensive assistance of 1 person with grooming needs. Review of the most current plan of care for R35 did not include the resident's grooming needs. When interviewed on 2/11/16, at 8:48 a.m. R35 indicated she was not aware of her notable long facial hairs as she was unable to see them. R35 stated she is bothered by these long facial hairs once she's made aware. R35 revealed the staff may shave her weekly, but was unsure whether it occurred. Interview with nursing assistant (NA)-A on 2/11/16	F 312	F312 It is the current policy and procedure of GSS Westbrook to assess and develop appropriate care plans, regarding activities of daily living, for every resident. The care plans for R35 and R11 were updated to reflect residents personal hygiene needs relating to facial hair grooming, and appropriate interventions 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 educated regarding facial hair grooming needs, corresponding care planning, and appropriate interventions.	3/18/16

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F 312	Continued From page 5 at 9:07 a.m. indicated R35's plan of care did not include grooming needs/shaving for R35 and 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. verified R17 had been assessed as requiring assistance with grooming/shaving needs but confirmed R35 did not have a plan of care which included assistance with shaving/grooming 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	F 312	A weekly audit will be conducted by DNS or designee x 3 weeks, then monthly x 1. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated. Corrected date: March 18, 2016	

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F 312	Continued From page 6 regarding the presence of facial hair on her upper lip and chin area. R11 reached and rubbed the areas on her upper lip and chin and stated staff had not offered to shave the areas for her and she would like to have this done. When interviewed on 2/11/16, at 9:50 a.m. licensed practical nurse (LPN)-A observed R11 and then indicated R11 should have been shaved on her scheduled bath day to remove the facial hairs. When interviewed on 2/11/16, at 10:55 a.m. NA-B stated residents are checked for facial hair and shaved when they 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.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		3/18/16

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F 329	Continued From page 7 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility to evaluate the continued use of psychoactive medications for 1 of 5 residents (R13) reviewed for unnecessary medication. Findings include: R13's Diagnosis report obtained in the medical record included: depressive episodes and anxiety disorder. Physician orders dated 2/16, indicated R13 was prescribed Ativan 0.25 milligrams (mg) three times a day (anti-anxiety) and Cymbalta 40 mg daily (antidepressant). Review of the most current Minimum Data Set (MDS) dated 12/17/15, identified R13 as having no behaviors in the assessment period. The resident was identified as having trouble concentrating, feeling tired, having little energy and feeling down. Review of the progress notes over the past 6 months did not include any mood and behaviors that were identified on the MDS during the assessment period. Review of the current plan of care identifies R13	F 329	F329 It is the current policy and procedure of GSS – Westbrook to ensure residents' drug regimens are free from unnecessary medications. R13 had an increase in her Cymbalta on December 22, 2015 and an increase in her Ativan on January 7, 2016. Pharmacist consultant visited January 26, 2016 but did not list any concerns or recommendations over R13's psychoactive medications. R13 was seen on January 21, 2016, and physician's note from the visit stated, current medications were reviewed and are to be continued without change. The progress note also stated R13 has tolerated increased Cymbalta and to continue Ativan at this time. A risk and benefit statement was obtained from physician in regards to R13's psychoactive medications. R13's care plan was updated March 2, 2016 to assess for continuing need for	

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F 329	Continued From page 8 as having alterations in mood and anxiety. Interventions included: observe for signs and symptoms of mood changes that include feeling sad and depressed. Review of the physician notes did not include an evaluation of R13's prescribed psychoactive medications related to the continued need and current dose/reduction. When interviewed on 2/11/16, at 8:30 a.m. R13 indicated she becomes weepy at times in the winter months but was unsure whether her current medications were helping her feel better. R13 was observed to be calm and relaxed at this time. Interview with nursing assistant (NA)-A on 2/11/16, at 9:00 a.m. indicated R13 will get anxious about placement in the nursing home but is pleasant and cooperative. Interview with registered nurse (RN)-A on 2/11/16, at 10:00 a.m. confirmed R13's psychoactive medications had not been reassessed for continued use in the past year.	F 329	psychoactive medications as well as to provide thorough documentation of behaviors. All residents currently using psychoactive medications have been evaluated for unnecessary medications. Pharmacy consultant informed of the details of the F329 tag. Pharmacy consultant to continue to conduct monthly medication reviews with emphasis on psychoactive medications and provide report and recommendations to designated personnel. Pharmacy recommendations will be reviewed monthly x 3 by behavior/reduction committee to ensure appropriate recommendations are made related to evaluating the continued use of psychoactive medications. QAPI committee will review findings and make recommendations. Corrected date: March 18, 2016	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		3/18/16

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F 428	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility consulting pharmacist failed to identify irregularities related to ongoing monitoring for effectiveness of psychoactive medications for 1 of 5 residents (R13) reviewed for unnecessary medication. Findings include: R13's Diagnosis report obtained in the medical record included: depressive episodes and anxiety disorder. Physician orders dated 2/16, indicated R13 was prescribed Ativan 0.25 milligrams (mg) three times a day (anti-anxiety) and Cymbalta 40 mg daily (antidepressant). Review of the most current Minimum Data Set (MDS) dated 12/17/15, identified R13 as having no behaviors in the assessment period. The resident was identified as having trouble concentrating, feeling tired, having little energy and feeling down. Review of the progress notes over the past 6 months did not include any mood and behaviors that were identified on the MDS during the assessment period. Review of the current plan of care identifies R13 as having alterations in mood and anxiety. Interventions included: observe for signs and symptoms of mood changes that include feeling sad and depressed.	F 428	F428 It is the current policy and procedure of GSS – Westbrook to ensure residents' drug regimens are reviewed at least once monthly and that any irregularities are reported and acted on. The pharmacist has reviewed R13's current medications, and they are appropriate. All residents have been reviewed by pharmacist, and any irregularities related to ongoing monitoring for effectiveness of psychoactive medications were reviewed, and appropriate recommendations were made. Pharmacy consultant has been informed of the details of the F428 tag. Pharmacy consultant to continue to conduct monthly medication reviews with emphasis on psychoactive medications and provide report and recommendations to designated personnel. Review findings at QAPI committee with appropriate recommendations. Corrected Date: March 18, 2016	

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F 428	Continued From page 10 Review of the physician notes did not include an evaluation of R13's prescribed psychoactive medications related to the continued need and current dose/reduction. Pharmacy reviews in the past year did not include any recommendations for an evaluation of the continued need at current dose and/or dose reduction related to R35's psychoactive medications. When interviewed on 2/11/16, at 8:30 a.m. R13 indicated she becomes weepy at times in the winter months, but was unsure whether her current psychoactive medications were helping her feel better. R13 was observed to be calm and relaxed at this time. Interview with nursing assistant (NA)-A on 2/11/16, at 9:00 a.m. indicated R13 will get anxious about placement in the nursing home but is pleasant and cooperative. Interview with registered nurse (RN)-A on 2/11/16, at 10:00 a.m. confirmed R13's psychoactive medications had not been assessed for continued use in the past year. When attempted to contact the facility consulting pharmacist by phone, a return call did not occur.	F 428		

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	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2016**

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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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2016**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

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

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

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

2. The actual, or proposed, completion date.

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

Building 01 of Good Samaritan Society Westbrook was constructed as follows:
The original building was built in 1961, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction;
The first addition was built in 1969, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction;
The second addition was built in 2001, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction

The facility has a complete automatic fire alarm system, with smoke detection in the corridors and in spaces open to the corridors, which is monitored for automatic fire department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2016**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 notification. The facility has a capacity of 34 beds and had a census of 28 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 FINDINGS INCLUDE: During Facility Inspection on February 10, 2016 between 10:00 AM and 12:30 PM, observation during the inspection revealed the following discrepancies with Hazardous Areas: 1.) Oxygen storage room door did not latch into the door frame upon closing and the door had a	K 029	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. K29 It is the current policy and procedure of GSS - Westbrook to maintain the facility so that it is in compliance with Life Safety Code standards and regulations. 1. A new door handle was installed on the oxygen room door so that it latches into the door frame upon closing. Also, the door penetration was filled with	3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2016**

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GOOD SAMARITAN SOCIETY - WESTBROOK	**149 FIRST STREET, BOX 218 WESTBROOK, MN 56183**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 penetration above the door handle. 2.) Utility Room in the Service Hallway did not latch into the door frame upon door closing. 3.) Mechanical Room-200 Wing, needs a self closing device installed. 4.) Electrical Room-200 Wing needs the self door closing device repaired. 5.) Boiler Room door does not self close, is not rated and has a door latch that will not latch into the door frame. NOTE: All Hazardous Areas need to be checked to ensure compliance. These deficient practices were observed by the Facility Maintenance Director.	K 029	fireproof caulk and a cover placed over the site. Work was completed on 02/24/2016. 2. The latch on the utility room door was adjusted so that the door latches into the door frame upon closing. Work was completed on 02/24/2016. 3. A new self-closing device was installed on the mechanical room door 200 wing. Work was completed 0n 02/19/2016. 4. A new self-closing device was installed on the electrical room door 200 wing. Work was completed on 02/19/2016. 5. Bids are being obtained for a new door and self-closing device for the boiler room so that it complies with LSC standards and regulations. 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	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership.	K 050		3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2016**

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

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K 050	Continued From page 4 Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 FINDINGS INCLUDE: During documentation review on February 10, 2016 between 10:00 AM and 12:30 PM,fire drill documentation revealed that the night shift (11pm-7am) fire drills were not conducted during varying times. 1st quarter-0300hrs, 2nd quarter-03:15 hrs, 3rd quarter 23:15 hrs and 4th quarter-03:00hrs. This deficient practice was observed by the Facility Maintenance Director.	K 050	K50 It is the current policy and procedure of GSS – Westbrook to conduct fire drills at varying times on each shift. Staff members were educated as to the requirement to conduct fire drills at varying times on each shift. Audits will be conducted monthly to ensure fire drills are conducted at varying times on each shift.	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with	K 052		3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2016**

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

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K 052	Continued From page 5 applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7. FINDINGS INCLUDE: Documentation review indicated that the last annual fire alarm inspection was conducted on 02/04/2015. This deficient practice was observed by the Facility Maintenance Director.	K 052	K52 It is the current policy and procedure of GSS – Westbrook to have the fire alarms inspected annually by a certified fire alarm inspection contractor. The contractor was contacted and advised that their most recent fire alarm inspection had been conducted outside of the 12-month LSC requirement. The contractor has changed the inspection schedule so that the fire alarms will be inspected prior to the end of the 12-month LSC requirement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **03 - 2007 ADDITION** B. WING _____	**02/10/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 15, 2015. At the time of this survey, Building 03 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 18 New 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 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **03 - 2007 ADDITION** B. WING _____	**02/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 03 of Good Samaritan Society Westbrook includes a 2007 building addition, consisting of a new main entrance, lobby and offices. In 2011, the dietary department was fully remodeled. These additions are one-story, have no basement, are fully sprinklered and were determined to be of Type V(111) construction. The facility has a complete automatic fire alarm system, with smoke detection in the corridors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 34 beds and had a census of 28 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. This STANDARD is not met as evidenced by: One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 18.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the	3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **03 - 2007 ADDITION** B. WING _____	**02/10/2016**

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GOOD SAMARITAN SOCIETY - WESTBROOK	**149 FIRST STREET, BOX 218 WESTBROOK, MN 56183**

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K 029	Continued From page 2 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 18.3.2.1 FINDINGS INCLUDE: During Facility Inspection on February 10, 2016 between 10:00 AM and 12:30 PM, observation during the inspection revealed the following discrepancy within a Hazardous Area: 1.) Pass-Thru Window from Kitchen Dish Room into Hallway does not close upon fire alarm activation and is not held open by a fusible link. NOTE: All Hazardous Areas need to be checked to ensure compliance. These deficient practices were observed by the Facility Maintenance Director.	K 029	statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. K29 It is the current policy and procedure of GSS - Westbrook to maintain the facility so that it is in compliance with Life Safety Code standards and regulations. 1. A new door handle was installed on the oxygen room door so that it latches into the door frame upon closing. Also, the door penetration was filled with fireproof caulk and a cover placed over the site. Work was completed on 02/24/2016. 2. The latch on the utility room door was adjusted so that the door latches into the door frame upon closing. Work was completed on 02/24/2016. 3. A new self-closing device was installed on the mechanical room door - 200 wing. Work was completed 0n 02/19/2016. 4. A new self-closing device was installed on the electrical room door - 200 wing. Work was completed on 02/19/2016. 5. Bids are being obtained for a new door and self-closing device for the boiler room so that it complies with LSC standards and regulations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **03 - 2007 ADDITION** B. WING _____	**02/10/2016**

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K 029	Continued From page 3	K 029	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	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 FINDINGS INCLUDE: During documentation review on February 10, 2016 between 10:00 AM and 12:30 PM,fire drill	K 050	K50 It is the current policy and procedure of GSS – Westbrook to conduct fire drills at varying times on each shift. Staff members were educated as to the requirement to conduct fire drills at varying times on each shift. Audits will be conducted monthly to ensure fire drills are conducted at varying times on each shift.	3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 050	Continued From page 4 documentation revealed that the night shift (11pm-7am) fire drills were not conducted during varying times. 1st quarter-0300hrs, 2nd quarter-03:15 hrs, 3rd quarter 23:15 hrs and 4th quarter-03:00hrs. This deficient practice was observed by the Facility Maintenance Director.	K 050		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7. FINDINGS INCLUDE: Documentation review indicated that the last annual fire alarm inspection was conducted on 02/04/2015. This deficient practice was observed by the Facility Maintenance Director.	K 052	K52 It is the current policy and procedure of GSS – Westbrook to have the fire alarms inspected annually by a certified fire alarm inspection contractor. The contractor was contacted and advised that their most recent fire alarm inspection had been conducted outside of the 12-month LSC requirement. The contractor has changed the inspection schedule so that the fire alarms will be inspected prior to the end of the 12-month LSC requirement.	3/18/16

MDH
Minnesota
Department
of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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Telephone: (651) 201-4112
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00082	A. BUILDING: _____ B. WING _____	02/11/2016

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: EPOC: 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	2 000	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.	

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2 000	Continued From page 1 delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 9 to February 11, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000	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 which 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.	

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a plan of care for for 1 of 3 residents (R17) reviewed for bruises and for 2 of 3 residents (R35, R11) reviewed for activities of daily living (ADL's). Findings include: During observations on 2/9/16, at 3:00 p.m. and on 2/10/16, at 10:08 a.m. it was noted that R17 had a 50 cent size bruise on the inner right arm and a 25 cent size bruise on the inner left arm. Both bruises were dark purplish in color. When interviewed during the observed times, R17 she was unaware of these bruises nor how she obtained them.	2 560	Corrected	3/22/16

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2 560	Continued From page 3 Review of R17's progress note dated 1/29/16, identified a bruised area on the right forearm. The area measured 1.0 cm by 4.0 cm. Review of the weekly skin assessment form dated 1/31/16, did not include R17's bruises on the arms. The assessment also identified the resident as having no skin issues. Review of R17's current physicians orders indicated R17 receives Coumadin daily (a blood thinner). Review of the most current plan of care did not include R17 as being at risk for bleeding/bruising nor the use of a blood thinner. No development of a plan of care which identified interventions were listed. Interview with the director of nursing (DON) on 2/10/16 at 8:20 a.m., confirmed R17's bruising should have been monitored and care planned due to her risk of bruising related to the use of a blood thinner. R35 was observed on 2/10/16 and 2/11/16 to have long facial hairs on the chin. Review of R35's quarterly Minimum Data Set (MDS) dated 1/20/16, identifies R35 as requiring extensive assistance of 1 person with grooming needs. Review of the most current plan of care for R35 did not include the resident's grooming needs. When interviewed on 2/11/16, at 8:48 a.m. R35 indicated she was not aware of her notable long facial hairs because she was unable to see them. R35 stated she would be bothered by these long facial hairs if she had known. R35 revealed the staff may shave her weekly, but was unsure. Interview with nursing assistant (NA)-A on 2/11/16 at 9:07 a.m. indicated R35's plan of care did not include grooming needs/shaving for R35 and	2 560		

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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 lip and chin area. R11 reached and rubbed the areas on her upper lip and chin and stated staff	2 560		

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2 560	Continued From page 5 had not offered to shave the areas for her and she would like to have this done. When interviewed on 2/11/16, at 9:50 a.m. licensed practical nurse (LPN)-A observed R11 and then indicated R11 should have been shaved on her scheduled bath day to remove the facial hairs. When interviewed on 2/11/16, at 10:55 a.m. NA-B stated residents are checked for facial hair and shaved when they receive their weekly bath. On 2/11/16, at 11:30 a.m. RN-A verified the care plan did not include interventions for personal grooming related to facial hair and should have. No policy was provided which addressed the need for providing shaving/grooming of female residents. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure care plans are developed and reflect each residents current care needs. The DON or designee could educate all appropriate staff on the policies/procedures, and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining	2 850		3/18/16

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2 850	Continued From page 6 adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services for 2 of 3 residents (R11, R35) reviewed for activities of daily living (ADL's). Findings include: R35 was observed on 2/10/16 and 2/11/16 to have long facial hairs on the chin. Review of R35's quarterly Minimum Data Set (MDS) dated 1/20/16, identifies R35 as requiring extensive assistance of 1 person with grooming needs. Review of the most current plan of care for R35 did not include the resident's grooming needs. When interviewed on 2/11/16, at 8:48 a.m. R35 indicated she was not aware of her notable long facial hairs as she was unable to see them. R35 stated she is bothered by these long facial hairs once she's made aware. R35 revealed the staff may shave her weekly, but was unsure whether it occurred. Interview with nursing assistant (NA)-A on 2/11/16 at 9:07 a.m. indicated R35's plan of care did not include grooming needs/shaving for R35 and 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. verified R17 had been assessed as requiring assistance with grooming/shaving	2 850	Corrected	

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2 850	Continued From page 7 needs but confirmed R35 did not have a plan of care which included assistance with shaving/grooming 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 lip and chin area. R11 reached and rubbed the areas on her upper lip and chin and stated staff had not offered to shave the areas for her and she would like to have this done. When interviewed on 2/11/16, at 9:50 a.m. licensed practical nurse (LPN)-A observed R11 and then indicated R11 should have been shaved	2 850		

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2 850	Continued From page 8 on her scheduled bath day to remove the facial hairs. When interviewed on 2/11/16, at 10:55 a.m. NA-B stated residents are checked for facial hair and shaved when they 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. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for meeting personal grooming for residents the need to keep nails trimmed and clean and facial hair for women trimmed if the woman had identified this as important to them. Routine audits could be conducted to ensure the appropriate grooming has been provided and the results could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in	21535		3/18/16

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21535	Continued From page 9 part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility to evaluate the continued use of psychoactive medications for 1 of 5 residents (R13) reviewed for unnecessary medication. Findings include: R13's Diagnosis report obtained in the medical record included: depressive episodes and anxiety disorder. Physician orders dated 2/16, indicated R13 was prescribed Ativan 0.25 milligrams (mg) three times a day (anti-anxiety) and Cymbalta 40 mg daily (antidepressant). Review of the most current Minimum Data Set (MDS) dated 12/17/15, identified R13 as having no behaviors in the assessment period. The resident was identified as having trouble concentrating, feeling tired, having little energy and feeling down. Review of the progress notes over the past 6 months did not include any mood and behaviors that were identified on the MDS	21535	Corrected	

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21535	Continued From page 10 during the assessment period. Review of the current plan of care identifies R13 as having alterations in mood and anxiety. Interventions included: observe for signs and symptoms of mood changes that include feeling sad and depressed. Review of the physician notes did not include an evaluation of R13's prescribed psychoactive medications related to the continued need and current dose/reduction. When interviewed on 2/11/16, at 8:30 a.m. R13 indicated she becomes weepy at times in the winter months but was unsure whether her current medications were helping her feel better. R13 was observed to be calm and relaxed at this time. Interview with nursing assistant (NA)-A on 2/11/16, at 9:00 a.m. indicated R13 will get anxious about placement in the nursing home but is pleasant and cooperative. Interview with registered nurse (RN)-A on 2/11/16, at 10:00 a.m. confirmed R13's psychoactive medications had not been reassessed for continued use in the past year. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could establish procedures, educate staff and audit to ensure that residents drug regimen is free of irregularities and contraindications and appropriate monitoring is being completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

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21540	Continued From page 11	21540		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility consulting pharmacist failed to identify irregularities related to ongoing monitoring for effectiveness of psychoactive medications for 1 of 5 residents (R13) reviewed for unnecessary medication. Findings include: R13's Diagnosis report obtained in the medical	21540	Corrected	3/18/16

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21540	Continued From page 12 record included: depressive episodes and anxiety disorder. Physician orders dated 2/16, indicated R13 was prescribed Ativan 0.25 milligrams (mg) three times a day (anti-anxiety) and Cymbalta 40 mg daily (antidepressant). Review of the most current Minimum Data Set (MDS) dated 12/17/15, identified R13 as having no behaviors in the assessment period. The resident was identified as having trouble concentrating, feeling tired, having little energy and feeling down. Review of the progress notes over the past 6 months did not include any mood and behaviors that were identified on the MDS during the assessment period. Review of the current plan of care identifies R13 as having alterations in mood and anxiety. Interventions included: observe for signs and symptoms of mood changes that include feeling sad and depressed. Review of the physician notes did not include an evaluation of R13's prescribed psychoactive medications related to the continued need and current dose/reduction. Pharmacy reviews in the past year did not include any recommendations for an evaluation of the continued need at current dose and/or dose reduction related to R35's psychoactive medications. When interviewed on 2/11/16, at 8:30 a.m. R13 indicated she becomes weepy at times in the winter months, but was unsure whether her current psychoactive medications were helping her feel better. R13 was observed to be calm	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00082	A. BUILDING: _____ B. WING _____	02/11/2016

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21540	Continued From page 13 and relaxed at this time. Interview with nursing assistant (NA)-A on 2/11/16, at 9:00 a.m. indicated R13 will get anxious about placement in the nursing home but is pleasant and cooperative. Interview with registered nurse (RN)-A on 2/11/16, at 10:00 a.m. confirmed R13's psychoactive medications had not been assessed for continued use in the past year. When attempted to contact the facility consulting pharmacist by phone, a return call did not occur. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the	21915		3/18/16

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21915	Continued From page 14 responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 23 resident families who reside in the facility. Findings include: When interviewed on 2/10/16, at 8:04 a.m. the social services designee (SSD) confirmed the facility did not have an existing family council. SSD further stated last sending out a letter to families in 2014 related to interest in forming a family council. SSD confirmed a letter of interest had not been sent to families in 2015. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure attempts are made to develop a family council. The administrator or her designee could develop monitoring systems to ensure attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915	Corrected	