DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 18, 2024

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: November 26, 2023

Dear Administrator:

On December 28, 2023, we informed you of imposed enforcement remedies.

On January 16, 2024, the Minnesota Departments of Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

K0521 -- S/S: F -- NFPA 101 -- Hvac Bld: 02

As a result of the revisit findings:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 26, 2024.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 26, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 26, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of December 12, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 26, 2024.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 May 26, 2024 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

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:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 28, 2023

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: November 26, 2023

Dear Administrator:

On December 12, 2023, we informed you that we may impose enforcement remedies.

On December 7, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 26, 2024.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 26, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 26, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 26, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Specialty Care Community will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 26, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Nikki Sassen, BSN, RN
Regional Operations Supervisor
St. Cloud Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 May 26, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals

Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:
https://forms.web.health.state.mn.us/form/NH-Dispute-Resolution

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/05/2023. At the time of this survey, Good Samaritan Society- Specialty Care Community was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 01/05/2024

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
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

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

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Good Samaritan Society - Specialty Care Community is a 3-story building with a basement that was built in 2012 and determined to be Type II (111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with complete smoke detection that is monitored for automatic fire department notification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 The facility has a capacity of 96 beds and had a census of 92 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/05/2023 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have been inspecting the emergency lighting in the facility. An interview with the Director of Facilities Management verified this deficient finding at the time of discovery.	K 291	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 that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. K291 (SS = F) Emergency Lighting 1. This citation has the potential to affect all residents. 2. This citation has the potential to affect all residents. 3. A form for documentation was created	1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 291	Continued From page 3	K 291	and placed in a checklist binder on 12/11/2023. The form will be filled out monthly as the test needs are brought to the Ancillary Services Supervisor□s attention. Subsequently, the location□s computerized preventative maintenance program will be updated to reflect the timing and frequency to help ensure compliance with NFPA code 4. Routine environmental audits of the checklist binder will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The Ancillary Services Supervisor and/or designee will be responsible for correction of deficiency by 1/15/2024.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 321	Continued From page 4 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, and 8.3.3.1. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 12/05/2023 at 11:38 AM, it was revealed by observation at the time of the survey that the soiled utility door on the second floor in the woodlands wing did not latch when the self-closing was tested. An interview with the Director of Facilities Management verified this deficient finding at the time of discovery.	K 321	K321 (SS = D) Hazardous Areas Enclosure 1. This citation has the potential to affect an isolated group of residents. 2. This citation has the potential to affect an isolated group of residents. 3. The 2nd floor Woodlands soiled utility door frame was inspected and was found to be loose from the wall and was remounted and secured on 12/5/2023. The self-closing door was tested and found to be able to shut completely by itself after the repair of the door frame. Moving forward, all doors will be inspected on a monthly basis and logged into the inspection check off list that is located in the Checklist binder in the facility manager's office. 4. Routine environmental audits of checklist binder will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The Ancillary Services Supervisor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 321	Continued From page 5	K 321	and/or designee will be responsible for correction of deficiency by 1/15/2024.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for	K 324	K324 (SS = D) Cooking Facilities 1. This citation has the potential to affect an isolated group of residents. 2. This citation has the potential to affect an isolated group of residents.	1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 324	Continued From page 6 Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/05/2023 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility provided me a kitchen hood inspection report dated 03/07/2023 but was not able to provide a report for an inspection completed within six months after that date. An interview with the Director of Facilities Management verified this deficient finding at the time of discovery.	K 324	3. The kitchen hood inspection dated 3/7/2023 was completed while no additional documentation had been found due to changing vendors. The semi-annual hood inspection was completed on 12/26/2023 and the inspection report was placed in the inspection binder. Moving forward, we are on a scheduled plan with the vendor to have the hood inspected every 6 months in accordance with the regulation. Subsequently, the location□s computerized preventative maintenance program will be updated to reflect the timing and frequency to help ensure compliance with NFPA code. 4. Routine environmental audits of the checklist binder will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The Ancillary Services Supervisor and/or designee will be responsible for correction of deficiency by 1/15/2024.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 353	Continued From page 7 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, observation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2, 5.3.2.1, and 5.3.2.2. These deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 12/05/2023 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have been completing quarterly inspections of their fire sprinkler system. 2. On 12/05/2023 between 08:45 AM and 12:30 PM, it was revealed by observation that at the time of the survey, the gauges on the fire sprinkler system were older than five years old. An interview with the Director of Facilities Management verified these deficient finding at the time of discovery.	K 353	K353 (SS = F) Sprinkler System □ Maintenance and Testing 1. This citation has the potential to affect all residents. 2. This citation has the potential to affect all residents. 3. The fire sprinkler vendor completed the annual inspection on 12/14/2023. Moving forward, the center is prescheduled for quarterly inspections through the fire sprinkler vendor. The gauges on the fire sprinkler system were replaced on 12/13/2023. Subsequently, the location□s computerized preventative maintenance program will be updated to reflect the timing and frequency to help ensure compliance with NFPA code. 4. Routine environmental audits of the checklist binder will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The Ancillary Services Supervisor and/or designee will be responsible for correction of deficiency by 1/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/05/2023 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have completed inspections of their fire dampers within the last four years. An interview with the Director of Facilities Management verified these deficient finding at the time of discovery.	K 521	K521 (SS = F) HVAC 1. This citation has the potential to affect all residents. 2. This citation has the potential to affect all residents. 3. The center is reviewing a proposed contract from Metropolitan Mechanical Contractors to ensure inspections are scheduled in accordance with state and federal regulation. 4. Routine environmental audits of the checklist binder will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The Ancillary Services Supervisor and/or designee will be responsible for correction of deficiency by 1/15/2024.	1/15/24
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 914	Continued From page 9 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/05/2023 between 08:45 AM and 12:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing	K 914	K914 (SS = F) Electrical Systems Maintenance and Testing 1. This citation has the potential to affect all residents. 2. This citation has the potential to affect all residents. 3. The Resident Room Electrical Plug Inspection Sheet was found on 12/6/2023 after exit. The Ancillary Services Supervisor made a new inspection binder and placed the electrical plug inspection in the checklist binder. Subsequently, the location s computerized preventative maintenance program will be updated to reflect the timing and frequency to help	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 914	Continued From page 10 that they have completed inspections of the electrical receptacles located in patient care rooms. An interview with the Director of Facilities Management verified this deficient finding at the time of discovery.	K 914	ensure compliance with NFPA code. 4. Routine environmental audits of the checklist binder will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The Ancillary Services Supervisor and/or designee will be responsible for correction of deficiency by 1/15/2024.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced	K 920		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING _____	**12/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 920	Continued From page 11 by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 12/05/2023 at 09:46 AM, it was revealed by observation that there were two refrigerators, a microwave, and a coffee maker plugged into one power strip in the Director of Facilities Management office. 2. On 12/05/2023 at 11:49 AM, it was revealed by observation that there was a refrigerator plugged into a power strip in the office labeled "Robins Nest". An interview with the Director of Facilities Management verified this deficient finding at the time of discovery.	K 920	K920 (SS = E) Electrical Equipment □ Power Cords and Extens 1. This citation has the potential to affect several residents. 2. This citation has the potential to affect several residents. 3. All power strips were removed from locations identified on 12/5/2023. 4. Routine environmental audits of the office spaces to ensure power cords and extensions are used appropriately will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The Ancillary Services Supervisor and/or designee will be responsible for correction of deficiency by 1/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02** B. WING _____	R **01/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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}	INITIAL COMMENTS Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 000}		
{K 521} SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on an on-site revisit, the facility remains out of compliance with the Federal requirements identified as deficient at the time of their recertification survey.	{K 521}	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 that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. This citation has the potential to affect	2/12/24

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

Electronically Signed | 01/19/2024

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
	245279	A. BUILDING **02** B. WING _____	R **01/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422**

(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 521}	Continued From page 1	{K 521}	all residents. 2. This citation had the potential to affect all residents. 3. The center has an inspection scheduled for 1/28/2024. 4. Routine environmental audits of the “checklist” binder will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The Ancillary Services Supervisor and/or designee will be responsible for correction of deficiency by 2/12/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 12/4/2023 to 12/7/2023 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/4/23 to 12/7/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52797494C / MN00084932 H52797527C / MN00086967 H52797526C / MN00091399 H52797528C / MN00092053 H52797495C / MN00092288 H52797497C / MN00092951 H52797496C / MN00094201 H52797498C / MN00094354 H52797492C / MN00098361 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	F 000		

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

Electronically Signed | 01/05/2024

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
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 584	Continued From page 2 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain wheelchairs in clean and sanitary manner for 4 of 4 residents (R3, R27, R36 and R57) reviewed who utilized wheelchairs. Findings include: R3's quarterly Minimum Data Set (MDS) dated 11/16/2023, indicated moderate cognitive impairment with a diagnosis of dementia and Huntington's disease and was dependent on staff for activities of daily living (ADLs). During observation on 12/5/23 at 10:37 a.m., R3's wheelchair was observed to be soiled with an unknown white and brown substance that was dried and splattered on both armrests and wheels. R27's quarterly MDS dated 10/12/2023, indicated significant cognitive impairment with a diagnosis of Huntington's disease (causes progressive breakdown of nerve cells in the brain) and was dependent on staff for ADLs.	F 584	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 that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F584 (SS = E) Safe/Clean/Comfortable/Homelike Environment The wheelchairs of the four residents identified as affected by the deficient practice (R3, R27, R36, and R57) were cleaned on 12/7/2023. On 12/7/2023 an environmental audit of the unit was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 584	Continued From page 3 During observation on 12/5/23 at 10:32 a.m., R27's wheelchair was observed to be soiled with an unknown white and brown substance that was dried and splattered on both armrests and was running down sides of wheelchair. R36's significant change MDS dated 9/21/23, indicated significant cognitive impairment with a diagnosis of Huntington's disease and was dependent on staff for ADLs. During observation on 12/5/23 at 10:34 a.m., R36's wheelchair was observed to be soiled with an unknown brown substance that was dried on both armrests and an unknown white substance that was dried and had run marks extending vertically down the right side of wheelchair. R57's quarterly MDS dated 10/26/2023, indicated significant cognitive impairment with a diagnosis of Huntington's disease and was dependent on staff for ADLs. During observation on 12/5/23 at 10:40 a.m., R57's wheelchair was observed to be soiled with an unknown yellow substance that was dried and crusted on both armrests, on the inside of both armrests that extended down to seat of wheelchair, on wheelchair cushion, and on the outside of wheelchair from armrests down to wheels. Wheels were covered with an unknown yellow substance. During interview on 12/5/23 at 2:16 p.m., R64 came to conference room and stated that she had a concern in regard to cleaning of the wheelchairs. R64 stated wheelchairs are never cleaned and has "stuff like shit and piss all over them."	F 584	completed to identify any other soiled assistive devices; no concerns noted. All residents that use a wheelchair have the potential to be affected by the deficient practice. As a result, a new assistive device wash schedule was created on 1/5/2024. To ensure systematic changes are sustained, re-education for all nursing and environmental services staff will be completed on how to wash a wheelchair as well as how to submit a work order for wheelchair washing outside of the schedule on 1/15/2024. Routine environmental audits of wheelchair cleanliness will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. The Director of Nursing and Ancillary Services Supervisor and/or designee will be responsible for correction of deficiency by 1/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 584	Continued From page 4 During interview on 12/6/23 at 11:07 a.m., nursing assistant (NA)-B stated if a wheelchair gets dirty after a meal, staff should wipe it down. NA-B stated housekeeping is responsible for cleaning of the wheelchairs but not aware of a schedule. During interview on 12/6/23 at 11:11 a.m., licensed practical nurse (LPN)-A confirmed R3, R27, R36 and R57's wheelchairs were dirty. LPN-A stated that wheelchairs were being washed in the past, but in the past several months, wheelchairs have not been cleaned. LPN-A stated maintenance is responsible for cleaning of the wheelchairs. During interview on 12/7/23 at 9:46 a.m., maintenance-A stated staff wipe down wheelchairs at night and if there are wheelchairs needing a deep clean, staff needed to complete a work order. Maintenance-A stated there had been a wheelchair cleaning schedule but due to being short-staffed, schedule has not been followed, and staff need to complete a work order for cleaning of a wheelchair. During record review on 12/7/23 at 10:53 a.m., reviewed completed work orders for cleaning of wheelchairs that maintenance had received and completed. There was only two that were submitted in the year of 2023 (2/3/23 and 9/13/23) from floor staff and 16 from therapy staff. During interview on 12/7/23 at 11:04 a.m., director or nursing (DON) stated staff wash down wheelchairs at night and that process had been in place before she started one year ago. DON stated if there was a wheelchair that was soiled, staff need to complete a work order for	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 584	Continued From page 5 maintenance. DON confirmed R3, R27, R36 and R57's wheelchairs were dirty and there was unidentified "stuff" all over them. DON stated the process they had in place for cleaning of wheelchairs was not working. DON stated it was important to ensure wheelchairs are clean due to cleanliness, dignity of the residents. A soiled wheelchair could cause issues with infection control. During interview on 12/7/23 at 1:39 p.m., administrator confirmed that there were no current outstanding work orders for cleaning of wheelchairs. During interview on 12/7/23 at 2:12 p.m., DON reviewed completed work orders and confirmed that process that they have in place was not working and staff need to be educated on the process and expectations of wheelchair cleaning as they must be aware of process. A wheelchair cleaning policy was requested but was not provided. The facility's Environmental Cleaning Principles policy, dated 10/19/21, indicated that environmental cleaning plays an important role in an infection control program. While most infections result from person-to-person transmission, the spread of infections from contaminated surfaces is significant and supports the need for good procedures and practices related to cleaning and disinfecting of surfaces. All staff members play a role and should be aware of the general principles of environmental cleaning and safety.	F 584		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 658	Continued From page 6 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration for 1 of 1 residents (R35) observed to receive an inhalation medication. Findings include: R35's Admission Record printed 12/7/23, indicated diagnoses of chronic obstructive pulmonary disease (COPD- a condition that blocks airflow and make it difficult to breathe), memory deficit following cerebral infarction (stroke), and bipolar disorder. R35's Order Summary Report printed 12/7/23, included budesonide-formoterol fumarate aerosol 160-4.5 mcg/act (medication used to prevent swelling in the lungs) 2 puffs inhaled orally two times a day for COPD, rinse mouth after each use. During observation on 12/5/23 at 8:14 a.m., licensed practical nurse (LPN)-B administered R35's morning medications, which included the budesonide inhaler. LPN-B handed the inhaler to R35 to complete two puffs. R35 completed the two puffs as ordered and handed back inhaler to LPN-B. LPN-B did not offer fluids or ask R35 to rinse mouth. LPN-B stated R35 often refused	F 658	F658 (SS = D) Services Provided Meet Professional Standards The order for R35□s budesonide-formoterol fumarate aerosol 160-4.5 mcg/act 2 puffs inhaled orally two times a day for COPD, rinse mouth after each use was updated to reflect, Notify nurse manager of refusal to rinse. on 1/2/2024. All residents with an order for steroid inhalers have the potential to be affected by the deficient practice. As a result, all residents with an order for steroid inhalers were reviewed on 1/2/2024 and the order was updated to reflect, Notify nurse manager of refusal to rinse. To ensure systematic changes are sustained, re-education for all clinical staff that administer medications will be completed on the importance of rinsing after using a steroid inhaler as well as notifying the unit nurse manager should a resident refuse to rinse after using a steroid inhaler. In addition, to ensure systematic changes are sustained, re-education for all clinical staff that administer medications was completed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 658	Continued From page 7 cares. During interview on 12/6/23 at 9:20 a.m., consulting pharmacist stated it is best practice to have the resident rinse their mouth after using this type of inhaler. It is important to avoid the resident getting thrush (a yeast infection of the mouth). During interview on 12/7/23 at 2:04 p.m., director of nursing (DON) stated it is important for the resident to rinse their mouth after using this type of inhaler to prevent thrush. The DON would expect the administering nurse to update to the nurse manager if the resident often refused to rinse mouth after inhaler. Facility policy Nebulizer Therapy dated 9/2023 failed to include guidance on rinsing mouth after administration of this kind of nebulizer.	F 658	Good Samaritan Society□s Nebulizer policy was completed on 1/15/2024. Routine environmental audits of medication administration with an emphasis on inhaler administration will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. The Director of Nursing Services and/or designee will be responsible for correction of deficiency by 1/15/2024.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess to assure safety with smoking for 1 of 2 residents (R8) who was smoking outside the facility.	F 689	F689 (SS = D) Free of Accident Hazards/Supervision/Devices A Tobacco Use Evaluation was completed for R35 on 12/7/2023 and his care plan	1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 689	Continued From page 8 Findings include: R35's significant change Minimum Data Set (MDS) dated 10/10/23, indicated R35 was cognitively intact, was not a current tobacco user and was independent with activities of daily living (ADLs). R35's diagnoses included cerebrovascular accident/stroke, seizure disorder, traumatic brain injury and chronic obstructive pulmonary disorder. During the facility entrance conference on 12/4/23 at 12:23 p.m. the administrator and the director of nursing (DON) stated the facility only had one resident who smoked off the balcony of his unit. R35's care plan printed 12/6/23, did not indicate R35 smoked. On 12/5/23 at 10:32 a.m., R35 was sitting in a wheelchair on the sidewalk in front of the building smoking a cigarette. Tremors were noted while holding the cigarette and bringing cigarette to his mouth. On 12/6/23 at 9:21 a.m., R35 was sitting in a wheelchair on the sidewalk in front of the building smoking a cigarette. Tremors were noted while holding cigarette in hand. R35 flicked cigarette butt on the street/sidewalk when finished smoking. On 12/6/23 at 10:55 a.m., nursing assistant (NA)-D stated R35 smokes and he goes outside very often and on his own. NA-D stated R35 stored his own cigarettes and lighter on him and/or in his room.	F 689	was updated. No other residents have the potential to be affected by the deficient practice; Specialty Care Community is a non-smoking facility. Newly admitted residents are informed of our non-smoking policy prior to admission. If a resident expresses a new desire to smoke, a Tobacco Use Evaluation would be completed, alternate options (ex. Nicotine patch) would be offered, and the resident would be required to smoke off-campus with supervision as needed. To ensure systematic changes are sustained, re-education for all nursing facility staff will be completed on Good Samaritan Society□s Smoking and Tobacco Use policy by 1/15/2024. Routine environmental audits of Tobacco Use Evaluation assessments will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. The Director of Nursing Services and/or designee will be responsible for correction of deficiency by 1/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 689	Continued From page 9 On 12/6/23 at 3:10 p.m., R35 stated facility staff talked to him about smoking and how it is a non-smoking facility. R35 stated he uses his electric wheelchair to go out on the sidewalk in front of the facility to smoke. R35 stated he stored cigarettes and lighter in his room and confirmed by showing them to surveyor. R35 stated purchased more on his own when needed. On 12/6/23 at 4:04 p.m. licensed practical nurse (LPN)-C stated R35 smoked and went outside by himself all the time. LPN-C stated R35 stored his cigarettes and lighter in his room. On 12/7/23 at 8:10 a.m. R35 was seated in a wheelchair on the sidewalk in front of the building smoking a cigarette. Tremors were noted while holding cigarette in hand. R35 flicked cigarette butt on the street/sidewalk when finished smoking. On 12/7/23 at 10:54 a.m., director of nursing (DON) stated she was aware that R35 smoked and that R35 went out to the sidewalk frequently to smoke. DON stated that she was instructed if a resident goes off the property to smoke, then a smoking assessment does not need to be completed. DON confirmed that R35 has not had a smoking assessment completed to ensure R35's safety. During record review, several notes from provider, between June 2023 to August 2023, stated that R35 continued to smoke and that R35 had moderate bilateral coarse tremor of both arms and hands. The facility Smoking and Tobacco Use policy revised 10/13/2022, indicated the facility does not	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 689	Continued From page 10 allow smoking on the premises. Prior or on admission the resident is informed of the facility's smoking and tobacco use policy. Upon admission, all residents who smoke or use tobacco products will be assessed using the Tobacco Use Assessment. Assessments also will be administered if a resident/client has a change in cognitive ability, judgment, manual dexterity and/or mobility. Care plans will be updated as needed. Staff members will designate acceptable outdoor location(s) for resident/client smoking. Such locations must be readily visible for staff member observation. The location must ensure precautions are taken for the resident's/client's individual safety, as well as the safety of others in the locations.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 690	Continued From page 11 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate management and routine care of an indwelling urinary catheter was provided for 1 of 1 resident (R49) reviewed for catheter care. Findings include: R49's significant change Minimum Data Set (MDS) assessment date 9/14/23, indicated R49 was cognitively intact, required moderate assistance with dressing and showering, substantial/maximal assistance with toileting hygiene and had an indwelling urinary catheter. R49's diagnoses included transient cerebral ischemic attack (a stroke that last only a few minutes), mild cognitive impairment, benign prostatic hyperplasia (noncancerous enlargement of the prostate gland), renal insufficiency (poor function of the kidneys that may be due to a reduction in blood-flow to the kidneys caused by renal artery disease), type 2 diabetes and	F 690	F690 (SS = D) Bowel/Bladder Incontinence, Catheter, UTI The order for R49, Change indwelling Foley with 16F Cauda Catheter 10cc balloon in the morning starting on the 2nd and ending on the 2nd every month related to Benign prostatic hyperplasia with lower urinary tract symptoms, was updated to include, Notify nurse manager of refusal. R49□s catheter was changed on 12/4/2023 as identified in a late entry note on 12/12/2023. All residents with an indwelling catheter have the potential to be affected by the deficient practice. All residents with an indwelling catheter were reviewed on 1/2/2024 to ensure the order for changing the indwelling catheter matches Good	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 690	Continued From page 12 long-term use of insulin. R49's physician orders included: "Change indwelling Foley with 16F Cauda Catheter 10cc balloon in the morning starting on the 2nd and ending on the 2nd every month related to Benign prostatic hyperplasia with lower urinary tract symptoms." During interview and observation on 12/4/23 at 2:28 p.m., R49 was sitting on his bed in his room and stated that he had a urinary catheter for "awhile" due to urinary retention. R49 stated the catheter had not been changed for over a month and it was supposed to be changed monthly. R49 stated that he was hoping it would be changed today as the nurse he preferred changing it was on duty. During interview on 12/6/23 at 9:27 p.m., R49 stated that his catheter was not changed on 12/4/23 and that he was hoping it would be changed today as the nurse he preferred was working again today. During record review on 12/6/23 at 4:27 p.m., treatment administration record indicated that R49's catheter had not been changed and no documentation was noted on why catheter change was not completed. During interview on 12/6/23 at 4:04 p.m., licensed practical nurse (LPN)-C stated that R49's catheter is changed once a month and is not aware of R49 refusing for it to be changed in the past. During interview on 12/7/23 at 11:00 a.m., director of nursing (DON) confirmed that R49's orders	F 690	Samaritan Society□s Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy as well as reads, Notify the nurse manager of refusal. To ensure systematic changes are sustained, re-education for all nursing facility staff will be completed on Good Samaritan Society□s Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy by 1/15/2024. Routine audits of catheter care/changes will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. The Director of Nursing Services and/or designee will be responsible for correction of deficiency by 1/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 690	Continued From page 13 indicated that catheter was to be changed on the 2nd of every month. DON stated that the task/order would display on the 2nd on the treatment administration record (TAR) for the nurse to complete and after the 2nd the order would not show up again to alert nursing that it had to still be completed. DON confirmed that the catheter was not signed off completed on the TAR on the 2nd and there was no documentation on why the catheter was not changed. DON stated this is important to ensure that the catheter is being changed to prevent UTI or complications and that it is not forgotten by nursing staff to complete. The facility policy "Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen-Assisted Living, Rehab/Skilled", dated 2/10/2023, indicated indwelling catheters are changed only when necessary or according to physician's orders and are connected to a closed drainage system. Purpose is to ensure appropriate use and care of urinary catheters.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 695	F695 (SS = D) Respiratory/Tracheostomy	1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 695	Continued From page 14 review, the facility failed to ensure that there were accurate orders in place for oxygen (O2) usage for 1 of 1 resident (R20) reviewed for oxygen therapy. Findings include: R20's significant change Minimum Data Set (MDS) assessment dated 10/16/23, indicated R20 had impaired cognition and required assistance with all activities of daily living (ADL)'s. R20's diagnoses included non-Alzheimer's Dementia (the loss of memory and other mental abilities severe enough to interfere with daily life), renal failure (one or both of the kidneys no longer function well on their own), chronic obstructive pulmonary disorder (condition involving constriction of the airways and difficulty or discomfort in breathing, and dependence on supplemental oxygen. During observation and interview on 12/4/23 at 2:12 p.m., R20 was sitting on the side of the bed and had oxygen nasal cannula placed in both nares. R20 was ashen in color and was taking short, quick breaths through pursed lips while talking. R20 stated he needed oxygen on at all times as it was hard for him to breath without oxygen. R20 stated he did not feel that the oxygen was currently on and asked surveyor to check his oxygen concentrator. Oxygen concentrator was set to "0" and was not on. Surveyor alerted licensed practical nurse (LPN)-D who checked R20's oxygen saturations and turned oxygen concentrator on. LPN stated R20's O2 saturations were 83. LPN-D stated R20 wears oxygen if his O2 saturations are below 90% and that R20 had his O2 saturations checked once every shift.	F 695	Care and Suctioning The order for R20 was updated and reads as, Supplemental O2 2 □ 4 L/min via Nasal Cannula Continuingly to maintain comfort. All residents that receive oxygen therapy have the potential to be affected by the deficient practice. All residents that receive oxygen therapy were reviewed on 1/2/2024 to ensure the current order for oxygen therapy was accurate. To ensure systematic changes are sustained, re-education for all nursing facility staff will be completed on Good Samaritan Society□s Oxygen Administration, Safety, Mask Types policy by 1/15/2024. Routine audits of oxygen therapy will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. The Director of Nursing Services and/or designee will be responsible for correction of deficiency by 1/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 695	Continued From page 15 During observation on 12/6/23 at 10:46 a.m., R20 was laying in bed with his eyes closed. R20 had oxygen nasal cannula in his nares but the oxygen concentrator was not on and was set to 0. During interview on 12/6/23 at 10:55 a.m., nursing assistant (NA)-D stated R20 needed continuous oxygen. NA-D stated R20 needed staff assistance to transfer from the portable oxygen tank to the oxygen concentrator, to turn off the portable tank and to turn on the concentrator. During interview on 12/6/23 at 4:04 p.m., LPN-C stated R20 needed continuous oxygen set at two liters at all times. LPN-C stated staff assist R20 with transferring from the portable oxygen tank to the oxygen concentrator in his room. During interview on 12/7/23 at 10:19 a.m., trained medication aide (TMA)-A stated R20 needed oxygen on at all times and staff needed to assist him with turning the oxygen on and off. During record review: - Provider visit note from 11/13/23 indicated R20 had acute and chronic respiratory failure with hypoxia and oxygen dependent at 2 L per nasal cannula, currently receiving hospice care. - Provider visit note from 10/10/23 indicated R20 had acute and chronic respiratory failure with hypoxia and continues on oxygen at 2 L per nasal cannula, currently receiving hospice care. Also indicated that R20 had idiopathic pulmonary fibrosis (chronic scarring lung disease) and is oxygen dependent. - Hospice comprehensive assessment and plan of care report dated 5/12/23 indicated an	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 695	Continued From page 16 order for oxygen - 2 liters continuous for shortness of breath and comfort. During interview on 12/7/23 at 10:50 a.m., director of nursing (DON) stated that R20's current oxygen order was for oxygen to be administered at two liters to keep O2 saturations above 90% and for R20's O2 saturations to be checked daily. DON reviewed physician visit and hospice notes and confirmed that R20 was dependent on oxygen and that R20 needs continuous oxygen set at 2L. DON stated the current order needed to be updated to reflect R20's dependence on oxygen. DON stated this was important so that R20 did not go into respiratory arrest and to aide in comfort measures for R20. The facility policy "Oxygen Administration, Safety, Mask Types - R/S, LTC, Therapy & Rehab" dated 6/30/23 indicated oxygen administration is carried out only with a medical provider order. A licensed nurse or other employee trained according to state regulations in the use of oxygen will be on duty and is responsible for the proper administration of oxygen to the resident. Staff are to verify physician order, attach nasal cannula, turn gauge to start flow rate at prescribed liters per minute (per physician's orders) and make sure that oxygen is flowing freely.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 755	Continued From page 17 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The facility failed to ensure the accurate administration of medications to meet resident needs for 1 of 2 (R21) reviewed for medication errors. Findings include: R21's quarterly Minimum Data set (MDS) dated, 10/26/23 identified resident as being 86 years old and having moderately impaired cognition and diagnoses of methicillin susceptible	F 755	F755 (SS = D) Pharmacy Srvs/Procedures/Pharmacist/Records 1)A review of the missing medication documentation for R21 was completed on 1/4/2024. The medication error incident was completed and the process for completed medication errors initiated. 2)All residents have the potential to be affected by the deficient practice. As a result, all nursing staff have been trained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 755	Continued From page 18 staphylococcus aureus infection (MRSA-nfections caused by specific bacteria that are resistant to commonly used antibiotics), staphylococcal arthritis (infection that spread to the joints through the bloodstream), type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, depression, unspecified radiculopathy cervical region (a nerve in the neck is pinched or irritated), restless leg syndrome , chronic pain syndrome and allergic rhinitis (runny nose due to allergies). R21's medication order summary report dated 12/7/23, indicated resident active orders for: - Buspirone hydrochloride (an antianxiety medication) 10 milligrams 3 times a day for anxiety disorder - Duloxetine hydrochloride (an antidepressant and nerve pain medication) 40 milligrams 2 times per day for neuropathy - Fluticasone propionate suspension (an allergy medication) 50 micrograms 2 times per day for allergies - Gabapentin (a medication for seizures and nerve pain) 300 milligrams 3 times a day for unspecified non-displaced fracture of 2nd cervical vertebra - Lidocaine cream (a topical medication for pain) 2 times a day to shoulder, neck, leg, feet for pain - Keflex (an antibiotic medication) 500 milligrams 3 times a day for life long suppression - Ropinirole hydrochloride (a medication for restless legs) 2 milligrams at bedtime for restless legs - Trazodone (an antidepressant medication) 100 milligrams at bedtime for sleep R21's medication administration record (MAR) for November 2023 lacked documentation indicating	F 755	on actions taken on missing medications/medication errors. 3) To ensure systematic changes are sustained, re-education for all nursing facility staff will be completed on Good Samaritan Society's Medication: Administration Including Scheduling and Medication Aides policy by 1/15/2024 4)Routine audits of the medication administration record (MAR) and treatment administration record (TAR) will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. Subsequently, missed medications for the last 24 hours are reviewed daily. 5)The Director of Nursing Services and/or designee will be responsible for correction of deficiency by 1/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 755	Continued From page 19 all 8 of these medications were given to resident per order on the evening of 11/6/23. When interviewed on 12/7/23 at 10:17 p.m., registered nurse (RN)-A acknowledged R21's MAR lacked documentation of administration of resident's for all 8 of these medications on the evening of 11/6/23. RN-A stated the lack of documentation could mean that staff did not sign out the medication or it wasn't given but would not know as the omission of documentation was not followed-up on timely. RN-A stated normally the electronic medical record (EMR) alerts staff to missing documentation and the alert reports are reviewed by leadership in a daily morning meeting however it appeared any alert regarding R21's medications on 11/6/23 was missed. RN-A stated this would be a medication error of possible omission and the facility reporting and investigation process should have been initiated including checking with staff, notifying the resident, the resident's family and the provider. When interviewed on 12/7/23 at 12:03 p.m., the director of nursing (DON) stated if the lack of documentation for R21's medications had been caught timely the process would have been for leadership to initiate a medication error incident and start an investigation including checking with staff to see if the medication had been given or not. The DON stated it was important to follow this process in order to determine if and why medications may have been missed, to make notifications to the provider allowing them to evaluate, make any order changes and monitor the resident for any ill effects. The facility policy Medication Administration dated 3/29/23, identified "An incident report will be	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 755	Continued From page 20 completed for all medication errors."	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident's drug regimen were free of drugs used for excessive duration for 1 of 5 residents (R21) reviewed for unnecessary medications. Findings include: R21's quarterly Minimum Data set (MDS) dated, 10/26/23 identified resident as being 86 years old	F 757	F757 (SS = D) Drug Regimen is Free from Unnecessary Drugs A review of the medication administration record (MAR) for R21 was completed 1/4/2024 on to ensure the MAR reflects the current orders for R21.	1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 757	Continued From page 21 and having moderately impaired cognition. R21's care plan dated 5/30/23, indicated resident needed assistance with all decision making, R21's medication orders dated 4/1/23, indicated resident had a medication order for Aspirin (ASA) 81 milligrams one time a day for supplement with a start date of 8/9/22. R21's consultant pharmacist's (Pharm D) medication review dated 4/27/23, indicated resident medical record did not demonstrate a need for ASA supplementation because resident had no history of coronary artery disease, acute coronary syndrome, angina, myocardial infarction, heart failure or stroke. The Parm D medication review also indicated ASA used in patients who did not have vascular disease show a higher rate of major bleeding and should be used with caution in adults aged 70 years old or older. The Pharm D recommended for R21's primary provider to consider discontinuation (D/C) of ASA. R21's provider signed and accepted the recommendation on 5/12/23. R21's Pharm D medication review dated 6/20/23, indicated the April 2023 suggestion to D/C ASA was accepted by the provider however was still being given and again suggested verifying with the provider if they had intended to D/C ASA use. The provider again indicated acceptance of the D/C of ASA by writing "D/C ASA" on the form with a signature dated 7/7/23. R21's Pharm D medication review dated 8/23/23, indicated the provider had responded to the two previous recommendations and questioned the ongoing need for ASA with the most recent	F 757	All residents have the potential to be affected by the deficient practice. As a result, all nurse managers have been trained on timely response to pharmacy recommendations. To ensure systematic changes are sustained, re-education for all nurse managers will be completed on Good Samaritan Society□s policy Pharmaceutical Services by 1/10/2024. The review of pharmacy recommendations has been included in weekly nurse manager review. Routine audits of pharmacy recommendations will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. The Director of Nursing Services and/or designee will be responsible for correction of deficiency by 1/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 757	Continued From page 22 recommendation being signed on 7/7/23 with a note to "D/C ASA" and "Despite this response, the order still shows as active". R21's provider again accepted the recommendation to D/C with a signature dated 10/2/23. R21's medication administration records (MARs) for May. June, July, August, September and October 2023, indicated continued use of ASA and administration of 144 doses from the date R21's provider ordered to D/C on 5/12/23 to 10/4/23 when it was D/C'd on the MAR. When interviewed on 12/7/23 at 10:17 a.m., (RN)-A stated the Pharm D's medication recommendation forms are printed out and given to the resident's provider when onsite to review. If the recommendation was more urgent it would be called or faxed to the provider. Normally an order should be followed up on and processed as quickly as possible but appears to have been missed for R21. When interviewed on 12/7/23 at 12:03 p.m., the director of nursing (DON) stated when the Pharm D comes for monthly medication reviews their recommendations were printed out and put in binders for leadership to follow-up on as soon as possible. The provider then would be called, or the form faxed, or given to them when onsite depending on the urgency of the recommendation. The facility nursing staff were responsible to process any provider order. The DON stated this process is important to ensure Pharm D recommendations are brought to the provider's attention in order to address timely. The DON acknowledged this process was missed and resulted in delay of discontinuation of R21's ASA.	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 757	Continued From page 23 When interviewed on 12/7/23 at 1:46 p.m., Pharm D stated R21's ASA would be considered an unnecessary medication because of her lack of cardiac related diagnosis. The facility policy Pharmaceutical Services dated 8/29/23, identified review of each resident's medication regimen is done at least monthly and any irregularities would be reported to the attending physician or the director of nursing services or both and "These reports must be acted upon and follow-up documentation maintained."	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 761	Continued From page 24 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly store and label an insulin pen for 1 of 2 residents (R49) reviewed who received insulin. In addition, the facility failed to ensure medications were properly labeled with directions for use for 1 of 4 residents (R34) reviewed for eye drop storage on Arrowhead unit. Findings include: R49's significant change Minimum Data Set (MDS) dated 9/14/23, indicated R49 was cognitively intact and needed extensive assist with activities of daily living (ADLs). R49's diagnoses included transient cerebral ischemic attack (a stroke that last only a few minutes), mild cognitive impairment, benign prostatic hyperplasia (noncancerous enlargement of the prostate gland), renal insufficiency (poor function of the kidneys that may be due to a reduction in blood-flow to the kidneys caused by renal artery disease), type 2 diabetes and long term use of insulin. During observation on 12/6/23 at 3:14 p.m., an opened insulin aspart pen (fast acting insulin) was observed in R49's individual medication cupboard. The insulin pen did not have a pharmacy label that included R49's name or directions for use. The insulin pen also did not contain date of when pen was opened. A full insulin pen contained 300 units with approximately 275 units of insulin remained in the	F 761	F761 (SS = D) Label/Store Drugs and Biologicals The medications without proper labels for R49 and R34 were properly disposed of on 12/7/2023. All residents receiving medications that require a label, such as insulin pens, eye drops, and inhalers were reviewed on 1/2/2024 to ensure the proper label was in place. To ensure systematic changes are sustained, re-education for all nursing facility staff will be completed on Good Samaritan Society□s policies Medication: Insulin Administration, Insulin Pens and Medication: Administration Including Scheduling and Medication aides by 1/15/2024. Routine audits of medication labels and storage will be completed weekly x4, then monthly x3. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. The Director of Nursing Services and/or designee will be responsible for correction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 761	Continued From page 25 pen. During record review, R49's orders included insulin aspart subcutaneous solution pen - injector 100 unit/mL (milliliter) - inject as per sliding scale: if 201-250 = 2 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 8 units; 401-999 = 10 units, subcutaneously two times a day for diabetes mellitus with breakfast and dinner. During interview and observation on 12/6/23 at 3:54 p.m., licensed practical nurse (LPN)-C stated all insulin pens should have a label from pharmacy with resident's name and instructions for use and be dated when opened. LPN-C confirmed insulin pen in R49's medication cupboard was not labeled or dated and immediately removed insulin pen from medication cupboard. LPN-C confirmed that R49 received insulin from this pen as R49 did not have any other pens in stock and there was insulin used from pen. LPN-C disposed of insulin pen and ordered a new one from pharmacy. LPN-C stated it was important for insulin pens to be individually labeled and dated so that the insulin is not given to another resident and the resident is not receiving expired insulin. During interview on 12/7/23 at 10:41 a.m., director of nursing stated all medications were expected to be labeled with resident name, open date, and expiration date she expected insulin pens be labeled with resident name and date opened. DON stated each pen needed to be dated, when they are opened, and are supposed to be individually labeled with resident's name and directions. DON stated it was important for the insulin pen to have a label so that the right	F 761	of deficiency by 1/15/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 761	Continued From page 26 patient receives the right insulin and amount. DON also stated it was important for the insulin pen to be labeled with the date pen was opened as the pen is only good for 28 days after opened. According to the Novolog aspart insulin package insert, "after initial use a vial may be kept at temperatures below 30 C (86 F) for up to 28 days but should not be exposed to excessive heat or light." The "Medication: Insulin Administration, Insulin Pens-R/S, LTC" policy dated 4/26/2023 indicated "Insulin pens are never shared between resident and used only with this safe handling procedure. Insulin pens must be clearly labeled with the name or other identifiers to verify that the correct pen is used on the correct person. Verify provider order, the expiration date, and the number of days the pen has been open. R34 During observation of medication cabinet on 10/6/23 at 7:41 a.m., R34's latanoprost eye drop label read Latanoprost 0.05% ophth solution instill 1 drop in both eyes at bedtime. The electronic medication administration (eMAR) indicated to give in right eye. R34's prednisolone 1% ophth susp label read instill 2 drops into affected eye (s) four times daily. EMAR indicated to instill 1 drop in left eye two times a day for glaucoma surgery. R34's Dorzolamide/Timolol solution eye drops read instill 1 drop in left eye twice a day. EMar for Dorzolamide/Timolol eye drops read to instill 1 drop in right eye two times a day for Eye Pressure. There was no change of order sticker placed on the medication bottle or label. During interview on 10/7/23 at 9:19 a.m., director	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

(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 761	Continued From page 27 of nursing (DON) confirmed the difference in instruction for each of the three eye drops. DON stated it was important to have had correct instructions so the eye drops would be placed in the correct eyes. DON confirmed change of order stickers are to be placed on label to indicate any change to the order. Facility policy Medication: Administration Including Scheduling and Medication Aides dated 3/29/23 included instructions to perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication	F 761		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 13, 2024

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: November 26, 2023

Dear Administrator:

On December 28, 2023, we notified you a remedy was imposed. On February 12, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 12, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 26, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 28, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 26, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 12, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 18, 2024

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: November 26, 2023

Dear Administrator:

On December 28, 2023, we informed you of imposed enforcement remedies.

On January 16, 2024, the Minnesota Departments of Public Safety completed a revisit and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is as follows:

K0521 -- S/S: F -- NFPA 101 -- Hvac Bld: 02

As a result of the revisit findings:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 26, 2024.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 26, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 26, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of December 12, 2023, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 26, 2024.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 May 26, 2024 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

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:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us