Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 21, 2023

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

RE: CCN: 245207
Cycle Start Date: June 22, 2023

Dear Administrator:

On August 14, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

August 21, 2023

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

Re: Reinspection Results
Event ID: M2RF12

Dear Administrator:

On August 14, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 22, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 31, 2023

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

RE: CCN: 245207
Cycle Start Date: June 22, 2023

Dear Administrator:

On June 22, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that 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.

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.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 22, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 22, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: 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
Cell: 1-507-308-4189

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING ______ B. WING ______	C 06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

(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 6/20/23-6/22/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 6/20/23-6/22/23, 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: H52072775C (MN00093901) H52072835C (MN00093898) H52072863C (MN00093902) H52072777C (MN00093895) H52072776C (MN00093897) H52072774C (MN00092578) 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 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/09/2023

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.

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F 000	Continued From page 1 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=D	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); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		8/10/23

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F 584	Continued From page 2 §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 1 of 1 resident (R12) reviewed who utilized wheelchairs. Findings include: R12's annual Minimum Data Set (MDS) dated 4/10/23, indicated R12 was cognitively intact and was diagnosed with dementia, depression, delusion disorder, weakness and required extensive assistance for activities of daily living (ADLs). During an interview on 6/20/23, at 2:07 p.m., family member (FM)-A stated R12's wheelchair was always dirty and smelled of urine. FM-A stated she cleaned R12's wheelchair in October but did not think it should be her responsibility to keep the wheelchair clean. During an observation on 6/21/23 at 7:21 a.m., R12's wheelchair smelled of urine, had food crumbs on the top of and under the wheelchair cushion, a dried white substance was scattered on both wheelchair pedals, and a sticky brown substance was on the left side of the wheelchair. During an interview on 6/22/23 at 8:08 a.m.,	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 centers allegation of compliance in accordance with section 7305 of the State Operation Manual. 1. Wheelchair for R12 was immediately cleaned 2. All residents have the potential to be affected by the deficient practice. Visual inspection of all wheelchairs was completed on 6/22/23. Soiled wheelchairs were cleaned when needed. 3. To ensure systemic changes are maintained, all wheelchairs will be power washed monthly. Housekeeping will wipe down wheelchairs weekly with deep room clean. Nursing to spot clean wheelchairs	

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F 584	Continued From page 3 housekeeper-A stated the housekeeping department cleaned wheelchairs after a resident discharged. Housekeeper-A stated housekeeping was told wheelchairs should be cleaned more often but stated they did not have time to. Housekeeper-A confirmed R12's wheelchair was dirty and should be cleaned. During an interview on 6/22/23 at 9:44 a.m., director of ancillary services stated housekeeping cleaned and disinfected wheelchairs after a resident discharged and the night shift nurses would clean wheelchairs when needed. During an interview on 6/22/23 at 10:08 a.m., administrator stated the facility did not have a cleaning schedule for wheelchairs but housekeeping would clean wheelchairs after a resident discharged and the night shift nurses would clean wheelchairs when needed. Administrator confirmed R12's wheelchair was dirty and should be cleaned. A facility policy for wheelchair cleaning was requested but administrator stated the facility did not have a policy.	F 584	PRN. Nursing and Housekeeping Staff will be educated on the new process. 4. Audits will be completed by DNS or designee via observation on wheelchair cleanliness. These audits on 5 random residents. These audits will be completed weekly x4, monthly x3 to ensure all wheelchairs are cleaned per wheelchair cleaning schedule. These audits will be taken to the QAPI committee monthly for review and further recommendations. 5. Completion Date: 8/10/2023 by DNS or designee	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		8/10/23

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F 604	Continued From page 4	F 604		

§483.12
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R26).

Findings include:

R26's significant change Minimum Data Set (MDS) dated 5/16/23, indicated severe cognitive impairment and was diagnosed with dementia, osteoarthritis, weakness, hypertension (high blood pressure), pain, chronic kidney disease and was dependent on staff for most activities of daily living (ADLs). The MDS further identified physical restraints were not used.

1. Pillow immediately removed from under sheet for R26
2. All residents have the potential to be affected by the deficient practice. Observation of all residents was completed to ensure positioning devices were being used properly
3. To ensure systemic changes are maintained, the facility has reviewed the policy on physical restraints and is appropriate at this time. Visual random checks will be completed to ensure pillows are being used properly for positioning. Nursing staff educated on proper use of positioning with pillows.
4. Audits will be completed by the DNS or

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F 604	Continued From page 5 R26's care plan dated 6/5/23, indicated R26 was at risk for falls related to weakness, deconditioning, gait and balance and history of falls and had the following interventions in place: encourage resident to participate in activities that promoted exercise, physical activity for strengthening and improved mobility, ensure resident was wearing appropriate footwear, avoid clothing that fit too loose, slippery or too long, frequent checks at night, provide assistance when needed, review and modify environmental hazards that could cause or contribute to fall, ensure and provide a safe environment (alternative call light, bed at appropriate height, avoid isolation). R26's physical device and/or restraint evaluation and review assessment dated 5/16/23, indicated R26 utilized grab bars but had no restraints in use. During an observation on 6/21/23 at 7:23 a.m., R26 was in bed. Bed was in low position, pushed up against the wall, one pillow tucked under fitted sheet on the right side of her body. During an observation on 6/21/23 at 9:32 a.m., R26 observed in bed with one pillow tucked under fitted sheet, on right side of body. During an observation and interview on 6/21/23 at 10:08 a.m., licensed practical nurse (LPN)-A administered medications to R26 while in bed. LPN-A stated the pillow under the fitted sheet prevented R26 from rolling or getting out of bed as R26 was at risk for falls. LPN-A stated R26 had weakness and would not be able to remove the pillow from under the sheet on her own.	F 604	designee via observation to ensure all pillows used for positioning are placed on top of the fitted sheet. These audits will be completed weekly x4, monthly x3 to ensure all pillows used for positioning are used properly. These audits will be taken to the QAPI committee for review and further recommendations. 5. Completion Date: 8/10/2023 by DNS or designee	

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F 604	Continued From page 6 During an observation and interview on 6/21/23 at 10:49 a.m., nursing assistant (NA)-A removed pillow that was under the fitted sheet and repositioned R26 onto her left side and placed the pillow back under the fitted sheet on the right side of R26's body. NA-A stated the pillow under the fitted sheet kept R26 from falling out of bed and to assist with repositioning. NA-A stated R26 would not be able to remove the pillow from under the sheet on her own. During an interview on 6/21/23 at 12:32 p.m., registered nurse (RN)-A stated the facility did not use restraints. RN-A stated pillows tucked under a fitted sheet would be considered a restraint. -at 12:36 p.m., RN-A confirmed R26 had one pillow tucked under the fitted sheet on the right side of R26's body and stated R26 would not be able to remove the pillow on her own. -at 12:55 p.m., RN-A removed pillow from under fitted sheet. During an interview on 6/21/23 at 1:48 p.m., director of nursing (DON) stated the facility did not use restraints. DON stated pillows should not be placed under a fitted sheet as it would be considered a restraint. DON stated she did not think R26 would be able to remove the pillow under the fitted sheet. DON expected all pillows used for repositioning would be placed over the sheet and not tucked under. A facility policy physical restraints/psychotropic medications alternatives dated 3/29/23, indicated the purpose of the policy was to provide non-pharmacological alternative to the use of a physical restraint or psychotropic medications.	F 604		
F 697 SS=D	Pain Management	F 697		8/10/23

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F 697	Continued From page 7 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure effective pain management for 1 of 1 resident (R189) reviewed for pain. Finding include: R189's admission Minimum Data Set (MDS) dated 6/13/23, included diagnoses of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, and orthopedic aftercare. It further included R189 required physical assistance of one staff with all activities of daily living (ADL), had frequent pain (rated at a 7 out of 10) that affected his sleep and daily activities. R189's physician's orders dated 6/11/23, included dilaudid oral tablet 2 milligrams (mg). Give 1 mg orally every 4 hours as needed for pain, give 1/2 tab which equals 1 mg every 4 hours as needed (PRN). It further included an order to encourage ice to left hip every shift for pain dated 6/16/23, and acetaminophen oral tablet 500 mg, give 1,000 mg by mouth three times a day for acute pain dated 6/12/23. P189's admission MDS dated 6/13/23, triggered a care area assessment (CAA) for pain which	F 697	1. LPN-A was verbally re-educated, at time of notification, on how to address unrelieved pain, including non-pharmacological interventions and/or notifying the provider when needed. Resident R189 was put into the bed to change position (non-pharmacological intervention). 2. All residents have the potential to be affected by the deficient practice. Nurses will continually monitor and observe for the success of the pain management plan and report to the nurse manager and prescriber as necessary to keep residents comfortable. 3. To ensure systemic changes are maintained, the facility has reviewed the policy on Pain Management and is current. Nursing staff was educated on the signs/symptoms of non-verbal expressions of pain, non-pharmacological interventions to relieve pain, and Policy for notifying provider for unrelieved pain. 4. Audits will be completed by the DNS or designees via observation, interview, and chart review on 5 random TCU residents to ensure pain management needs are being met. These audits will be completed weekly x4, monthly x3 to ensure resident	

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GOOD SAMARITAN SOCIETY - STILLWATER	**1119 OWENS STREET NORTH STILLWATER, MN 55082**

(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 697	Continued From page 8 included "resident has c/o [complains of] frequent pain that affects his sleep and his activities rated at a 7 when interviewed." It further included "staff will enourage non-pharmacological intervetnions for pain and provide scheduled/PRN [as needed] pain medications per medical doctor order and montior effectiveness or any side effects of pain medications. P189's care plan dated 6/12/23, included R189 had actue pain/discomfort related to hip fracture as evidenced by pain medication use, voices complaints of pain with interventions to notify health care provider if interventions are unsuccessful or if current complaint was a significant change from residents past experience of pain and attempt non-pharmacological interventions. During observation and interview on 6/21/23 at 1:55 p.m., R189 was sitting in his wheelchair in his room, he had facial grimacing, rocking back and forth, and rubbing his left thigh. He stated, "I need something to kick this pain. I have to ask for the medication and then I have to wait for it." R189 further stated the pain was in his left hip and right shoulder and rated the pain in his hip at an 8 (out of 10). He also stated he had received his medications a half an hour ago but "they're not working, and sometimes re-positioning helps." R189 asked if I (surveyor) could lay him down in bed because he was "in so much pain." The surveyor notified the nurse and staff assisted him into bed. During an observation and interview on 6/21/23 at 10:09 a.m., R189 was laying in bed. The head of his bed was elevated to almost a 90 degree angle and his right foot was pushed up against the	F 697	pain is being managed. These audits will be taken to the QAPI committee for review and further recommendations. 5. Completion Date: 8/10/2023 by DNS or designee	

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	245207	A. BUILDING ______ B. WING ______	C 06/22/2023

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F 697	Continued From page 9	F 697		

footboard. His left foot was off the edge of the bed. He stated he "wasn't doing so good," and had facial grimacing and was putting his hand up to his head and holding it. R189 pointed to his left groin area when asked where he was having pain and he rated it at "a 10 and even higher." He also stated he had a headache "that's way more then it should be!"
-At 10:18 a.m., the surveyor reported licensed practical nurse (LPN)-A, R189 was in pain and rated it at a "10." LPN-A stated she had already given him his pain medication at 7:27 a.m and he can't get another one until 11:27 a.m. LPN-A did not go into R189's room to assess him, offer any non-pharmacological pain interventions, or call the provider.
-At 10:40 a.m., nursing assistant (NA)-A was observed reporting to LPN-A R189 stated he was in pain and hadn't received his pain medication this morning. LPN-A stated he received his pain medication at 7:27 this morning and he can't get another one until 11:27 a.m. LPN-A did not go in and assess him, offer any non-pharmacological pain interventions, or call the provider.

During an interview on 6/21/23 at 10:50 a.m., NA-A stated R189 had been complaining of pain all morning and she had reported it to LPN-A on three separate occasions. NA-A stated LPN-A's response was the same each time stating he had already received his pain medication and he can't get it again until 11:27 a.m. NA-A stated she had worked with R189 before and he had never complained of pain, which was why she kept reporting it to the nurse so she made sure "she was staying on top of it."

During an interview on 6/21/23 at 11:09 a.m., LPN-B stated he would "try to use non

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F 697	Continued From page 10 pharmacological pain interventions such as ice, bio freeze [if there was a physician's order], and repositioning," if a resident was in pain and all pain medication had been given. LPN-B further stated "if that didn't work I would notify the supervisor or call the physician." During an interview on 6/21/23 at 11:12 a.m., registered nurse manager (RN)-A manager stated "we try non medication interventions, re-positioning, ice pack, etc. and if that doesn't work, then we would go to the nurse practioner or doctor. If they [resident] are screaming in pain, I would call the on-call or send them to the emergency room (ER)," when asked what nurses should do if a resident is in pain and all pain medications had been given. During an interview on 6/22/23 at 1:55 p.m., the director of nursing (DON) stated the nurses should be offering "ice, heat, moving [repositioning], and if the pain is still not relieved, they can call the provider to see if there's anything they can do," when asked what nurses should do if a resident is still in pain but has received all their pain medications. The DON also stated the nurses should be assessing for "non verbal signs of pain such as grimacing, guarding, crying, etc." The facility's policy on pain management dated 12/19/22, included the nurses working directly with residents must continually monitor and observe the resident for success of the pain management plan and report to the nurse manager and prescriber as necessary to keep the resident comfortable.	F 697		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		8/10/23

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F 812	Continued From page 11 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure foods were labeled, stored off the floor, and scoops were stored outside their bulk dry goods containers which had the potential to affect all 35 residents who consumed foods from the kitchen. Additionally, the facility failed to ensure the refrigerator in the main dining room was maintained. Findings include: During the initial kitchen tour with the supervisor of nutrition and food services (SNFS) on 6/20/23 at 12:59 p.m., observed the following:	F 812	1. By following our "Date Marking" and "Food Receiving" Policies we will ensure that foods are labeled, stored appropriately and that scoops are stored outside their bulk good containers we can ensure that residents will not be affected. 2. Determining future residents which may be affected by the tag will include any resident that receives food from the kitchen, which includes all residents. 3. To ensure systemic changes are maintained, we will provide individual education on each policy, record date of training and complete competency checklists. The "Cleaning Schedule" policy will help us ensure the fridge is kept	

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F 812	Continued From page 12 Kitchen Freezer: 1 box of strawberry ice cream was stored directly on the floor 1 box of potato fries was stored on the floor 1 box of crinkle cut fries was stored on the floor, SNFS stated, "foods should not be stored on the floor". 1 package of four chicken breasts were located in a bag was undated 1 opened bag of onions and peppers with no date and the bag was lying opened on the shelf Dry Storage: The sugar bin contained a plastic cup inside the bin located in the sugar The flour bin contained two plastic scoops located in the flour, SNFS stated, "the plastic cup and scoops should not be located in the sugar and flour bins, because it was touched by staff and should not be stored in the bins". Refrigerator Cooler: Brown colored fluid was located inside the bottom of the cooler A container was located in the cooler the SNFS stated, "It's my lunch". A plastic container SNFS stated, "looked like mashed potatoes but had no date or label so it would be discarded". During interview and observation on 6/22/23 at 8:13 a.m., in the main dining room, the main dining room refrigerator had a thick layer of ice located on the top of the inside of the refrigerator. The refrigerator contained thickened cranberry juices and prune juices. There was no	F 812	clean and monitored on a regular basis. Adding a thermometer will ensure foods are kept in a safe temperature range for residents. 4. Audits will be completed by the Food and Nutrition Supervisor or designee weekly x 4, Monthly x3 to ensure there are no deficient practices. These audits will be submitted to the QAPI committee for review and further recommendations 5.Completion date: 8/10/2023 by the Administrator, Food and Nutrition Supervisor or designee.	

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F 812	Continued From page 13	F 812		

thermometer located inside the refrigerator. Dietary Aide (DA)-A stated the kitchen staff took turns cleaning the refrigerator in the main dining room.

During interview on 6/22/23 at 8:21 a.m., nursing assistant (NA)-C verified the refrigerator did not have a thermometer and the thick build up of ice and stated the refrigerator could benefit from a cleaning or a defrosting.

During interview on 6/22/23 at 8:29 a.m. to 8:39 a.m., SNFS verified the refrigerator did not have a thermometer and had a thick build up of ice.

During interview on 6/22/23 at 12:12 p.m., SNFS stated food should not be stored on the floor because people could trip over the boxes and it could provide easy access for rodents. The buildup of ice in the refrigerator could cause temperatures to rise because it blocked the fan and the cooling element and there was no thermometer in the refrigerator.

A policy, Food-Supply Storage-Food and Nutrition Services dated 5/11/23, indicated personal food was not considered approved food and was not stored in the food preparation kitchen or location refrigerators and storage areas. All food supply items are stored off the floor. Foods that have been opened or prepared are placed in an enclosed container, dated, labeled and stored properly.

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K 000	INITIAL COMMENTS An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 21,2023. At the time of this survey, Good Samaritan Society 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. Healthcare Fire Inspections State Fire Marshal Division	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/09/2023

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.

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K 000	Continued From page 1	K 000		

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 Stillwater is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1962 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(111) construction. In 1992, an addition was constructed to the East side of the building that was determined to be of Type II(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as

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K 000	Continued From page 2 one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release	K 222		8/9/23

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K 222	Continued From page 3 upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility needed to maintain Egress doors per NFPA 101 (2012 edition), Life Safety Code	K 222	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by	

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K 222	Continued From page 4 section 19.2.2.2.6, and NFPA 80-2010, Standard for Fire Doors and Other Opening Protectives section 5.1.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/21/2023 at 11:00 AM, it was revealed by observation that the delay egress locks did not operate when tested by us at both the east and south wings. An interview with the facility maintenance director verified this deficient finding at the time of discovery.	K 222	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 centers allegation of compliance in accordance with section 7305 of the State Operation Manual. 1.Section 3 east and south doors were repaired By TCH and open properly. 2.Doors tested and ensured they function as stated on the signage. 3.Inspections will be made on a weekly basis to ensure the doors will continue to operate. 4.The supervisor of ancillary services or designee will be responsible for maintaining operation of the doors. 5.Date of completion 8/3/23	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for	K 372		8/9/23

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K 372	Continued From page 5 smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain Smoke Barrier Construction per NFPA 101 (2012 edition), Life Safety Code section 19.3.7.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On June 21, 2023, at 11:30 AM, it was revealed by observation that two penetrations were found in smoke barrier walls located above the doors by rooms 1-12 and 13-25 rooms. An interview with the facility Maintain Director verified this deficient finding at the time of discovery.	K 372	1. Penetrations in smoke barrier filled with Fireblock Insulating Foam Sealant, ICC-ES Evaluated ESR-1961, orange color, foam. 2. Check above drop ceiling and add more as needed 3. Check bi-annually and caulk with Fireblock Insulating Foam as needed. 4. The supervisor of ancillary services or designee will be responsible to fill penetrations that may occur. 5. Date of completion 6/26/23	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		8/9/23

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K 918	Continued From page 6 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to install Electrical Systems - NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110-2010 Standard for Emergency and Standby Power Systems 2010 section 5.6.5.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/21/2023 at 12:30 PM, it was revealed by observation that the new Winco generator does not have an emergency stop button located away from the primer generator.	K 918	1. Emergency stop button to be installed near the generator's annunciator panel inside the dining room. 2. Placed a call to Masters Electric, to install Emergency Stop Button. 3. Continue to monitor any new equipment installations to ensure they have a properly installed Emergency Stop Button if required. 4. The Supervisor of Ancillary Services will be responsible for ensuring the installation of the Emergency stop button if required. 5. Completed installed on 8/8/2023	

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	245207	A. BUILDING **01 - STILLWATER GOOD SAMARITAN** B. WING	**06/21/2023**

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K 918	Continued From page 7 An interview with the Facility Maintain director verified this deficient finding at the time of discovery.	K 918		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 31, 2023

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: M2RF11

Dear Administrator:

The above facility was surveyed on June 20, 2023 through June 22, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any 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

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 6/20/22-6/22/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following licensing orders are issued at 0505, 1015, 1095, and 1695. Please indicate in your electronic plan of correction you

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed during the survey: H52072775C (MN00093901) H52072835C (MN00093898) H52072863C (MN00093902) H52072777C (MN00093895) H52072776C (MN00093897) H52072774C (MN00092578) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for	2 000		

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2 000	Continued From page 2 text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints	2 505		8/10/23

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2 505	Continued From page 3	2 505		

Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given.

A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints.

B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms.

C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident.

D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest.

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2 505	Continued From page 4 E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from physical restraints for 1 of 1 resident (R26). Findings include: R26's significant change Minimum Data Set (MDS) dated 5/16/23, indicated severe cognitive impairment and was diagnosed with dementia, osteoarthritis, weakness, hypertension (high blood pressure), pain, chronic kidney disease and was dependent on staff for most activities of daily living (ADLs). The MDS further identified physical restraints were not used. R26's care plan dated 6/5/23, indicated R26 was at risk for falls related to weakness, deconditioning, gait and balance and history of falls and had the following interventions in place: encourage resident to participate in activities that promoted exercise, physical activity for strengthening and improved mobility, ensure resident was wearing appropriate footwear, avoid clothing that fit too loose, slippery or too long, frequent checks at night, provide assistance when needed, review and modify environmental hazards that could cause or contribute to fall, ensure and provide a safe environment (alternative call light, bed at appropriate height, avoid isolation).	2 505	corrected	

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2 505	Continued From page 5	2 505		

R26's physical device and/or restraint evaluation and review assessment dated 5/16/23, indicated R26 utilized grab bars but had no restraints in use.

During an observation on 6/21/23 at 7:23 a.m., R26 was in bed. Bed was in low position, pushed up against the wall, one pillow tucked under fitted sheet on the right side of her body.

During an observation on 6/21/23 at 9:32 a.m., R26 observed in bed with one pillow tucked under fitted sheet, on right side of body.

During an observation and interview on 6/21/23 at 10:08 a.m., licensed practical nurse (LPN)-A administered medications to R26 while in bed. LPN-A stated the pillow under the fitted sheet prevented R26 from rolling or getting out of bed as R26 was at risk for falls. LPN-A stated R26 had weakness and would not be able to remove the pillow from under the sheet on her own.

During an observation and interview on 6/21/23 at 10:49 a.m., nursing assistant (NA)-A removed pillow that was under the fitted sheet and repositioned R26 onto her left side and placed the pillow back under the fitted sheet on the right side of R26's body. NA-A stated the pillow under the fitted sheet kept R26 from falling out of bed and to assist with repositioning. NA-A stated R26 would not be able to remove the pillow from under the sheet on her own.

During an interview on 6/21/23 at 12:32 p.m., registered nurse (RN)-A stated the facility did not use restraints. RN-A stated pillows tucked under a fitted sheet would be considered a restraint.
-at 12:36 p.m., RN-A confirmed R26 had one pillow tucked under the fitted sheet on the right

Minnesota Department of Health

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2 505	Continued From page 6 side of R26's body and stated R26 would not be able to remove the pillow on her own. -at 12:55 p.m., RN-A removed pillow from under fitted sheet. During an interview on 6/21/23 at 1:48 p.m., director of nursing (DON) stated the facility did not use restraints. DON stated pillows should not be placed under a fitted sheet as it would be considered a restraint. DON stated she did not think R26 would be able to remove the pillow under the fitted sheet. DON expected all pillows used for repositioning would be placed over the sheet and not tucked under. A facility policy physical restraints/psychotropic medications alternatives dated 3/29/23, indicated the purpose of the policy was to provide non-pharmacological alternative to the use of a physical restraint or psychotropic medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review or revise policies, provide education for staff regarding physical restraint use. The Quality and Assessment Assurance (QAA) commitee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 505		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		8/10/23

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21015	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure foods were labeled, stored off the floor, and scoops were stored outside their bulk dry goods containers which had the potential to affect all 35 residents who consumed foods from the kitchen. Additionally, the facility failed to ensure the refrigerator in the main dining room was maintained. Findings include: During the initial kitchen tour with the supervisor of nutrition and food services (SNFS) on 6/20/23 at 12:59 p.m., observed the following: Kitchen Freezer: 1 box of strawberry ice cream was stored directly on the floor 1 box of potato fries was stored on the floor 1 box of crinkle cut fries was stored on the floor, SNFS stated, "foods should not be stored on the floor". 1 package of four chicken breasts were located in a bag was undated 1 opened bag of onions and peppers with no date and the bag was lying opened on the shelf Dry Storage: The sugar bin contained a plastic cup inside the bin located in the sugar The flour bin contained two plastic scoops located in the flour, SNFS stated, "the plastic cup and scoops should not be located in the sugar and flour bins, because it was touched by staff	21015	corrected	

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21015	Continued From page 8	21015		

and should not be stored in the bins".

Refrigerator Cooler:

Brown colored fluid was located inside the bottom of the cooler
A container was located in the cooler the SNFS stated, "It's my lunch".
A plastic container SNFS stated, "looked like mashed potatoes but had no date or label so it would be discarded".

During interview and observation on 6/22/23 at 8:13 a.m., in the main dining room, the main dining room refrigerator had a thick layer of ice located on the top of the inside of the refrigerator. The refrigerator contained thickened cranberry juices and prune juices. There was no thermometer located inside the refrigerator. Dietary Aide (DA)-A stated the kitchen staff took turns cleaning the refrigerator in the main dining room.

During interview on 6/22/23 at 8:21 a.m., nursing assistant (NA)-C verified the refrigerator did not have a thermometer and the thick build up of ice and stated the refrigerator could benefit from a cleaning or a defrosting.

During interview on 6/22/23 at 8:29 a.m. to 8:39 a.m., SNFS verified the refrigerator did not have a thermometer and had a thick build up of ice.

During interview on 6/22/23 at 12:12 p.m., SNFS stated food should not be stored on the floor because people could trip over the boxes and it could provide easy access for rodents. The buildup of ice in the refrigerator could cause temperatures to rise because it blocked the fan and the cooling element and there was no

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21015	Continued From page 9 thermometer in the refrigerator. A policy, Food-Supply Storage-Food and Nutrition Services dated 5/11/23, indicated personal food was not considered approved food and was not stored in the food preparation kitchen or location refrigerators and storage areas. All food supply items are stored off the floor. Foods that have been opened or prepared are placed in an enclosed container, dated, labeled and stored properly. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate infection control technique is maintained in the kitchen. The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy	21095		8/10/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21095	Continued From page 10 cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure foods were labeled, stored off the floor, and scoops were stored outside their bulk dry goods containers which had the potential to affect all 35 residents who consumed foods from the kitchen. Additionally, the facility failed to ensure the refrigerator in the main dining room was maintained. Findings include: During the initial kitchen tour with the supervisor of nutrition and food services (SNFS) on 6/20/23 at 12:59 p.m., observed the following: Kitchen Freezer: 1 box of strawberry ice cream was stored directly on the floor 1 box of potato fries was stored on the floor 1 box of crinkle cut fries was stored on the floor, SNFS stated, "foods should not be stored on the floor". 1 package of four chicken breasts were located in a bag was undated	21095	corrected	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00903	A. BUILDING: ______ B. WING ______	C 06/22/2023

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21095	Continued From page 11	21095		

1 opened bag of onions and peppers with no date and the bag was lying opened on the shelf

Dry Storage:

The sugar bin contained a plastic cup inside the bin located in the sugar
The flour bin contained two plastic scoops located in the flour, SNFS stated, "the plastic cup and scoops should not be located in the sugar and flour bins, because it was touched by staff and should not be stored in the bins".

Refrigerator Cooler:

Brown colored fluid was located inside the bottom of the cooler
A container was located in the cooler the SNFS stated, "It's my lunch".
A plastic container SNFS stated, "looked like mashed potatoes but had no date or label so it would be discarded".

During interview and observation on 6/22/23 at 8:13 a.m., in the main dining room, the main dining room refrigerator had a thick layer of ice located on the top of the inside of the refrigerator. The refrigerator contained thickened cranberry juices and prune juices. There was no thermometer located inside the refrigerator. Dietary Aide (DA)-A stated the kitchen staff took turns cleaning the refrigerator in the main dining room.

During interview on 6/22/23 at 8:21 a.m., nursing assistant (NA)-C verified the refrigerator did not have a thermometer and the thick build up of ice and stated the refrigerator could benefit from a cleaning or a defrosting.

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21095	Continued From page 12 During interview on 6/22/23 at 8:29 a.m. to 8:39 a.m., SNFS verified the refrigerator did not have a thermometer and had a thick build up of ice. During interview on 6/22/23 at 12:12 p.m., SNFS stated food should not be stored on the floor because people could trip over the boxes and it could provide easy access for rodents. The buildup of ice in the refrigerator could cause temperatures to rise because it blocked the fan and the cooling element and there was no thermometer in the refrigerator. A policy, Food-Supply Storage-Food and Nutrition Services dated 5/11/23, indicated personal food was not considered approved food and was not stored in the food preparation kitchen or location refrigerators and storage areas. All food supply items are stored off the floor. Foods that have been opened or prepared are placed in an enclosed container, dated, labeled and stored properly. SUGGESTED METHOD OF CORRECTION: The dietary director could review and revise food storage policicies and procedures. They could provide education to appropriate staff and deelop a monitioring system to ensrue compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors,	21695		8/10/23

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21695	Continued From page 13 ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN 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 1 of 1 resident (R12) reviewed who utilized wheelchairs. Findings include: R12's annual Minimum Data Set (MDS) dated 4/10/23, indicated R12 was cognitively intact and was diagnosed with dementia, depression, delusion disorder, weakness and required extensive assistance for activities of daily living (ADLs). During an interview on 6/20/23, at 2:07 p.m., family member (FM)-A stated R12's wheelchair was always dirty and smelled of urine. FM-A stated she cleaned R12's wheelchair in October but did not think it should be her responsibility to keep the wheelchair clean. During an observation on 6/21/23 at 7:21 a.m., R12's wheelchair smelled of urine, had food crumbs on the top of and under the wheelchair cushion, a dried white substance was scattered on both wheelchair pedals, and a sticky brown substance was on the left side of the wheelchair. During an interview on 6/22/23 at 8:08 a.m., housekeeper-A stated the housekeeping department cleaned wheelchairs after a resident discharged. Housekeeper-A stated housekeeping was told wheelchairs should be cleaned more often but stated they did not have time to.	21695	corrected	

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21695	Continued From page 14 Housekeeper-A confirmed R12's wheelchair was dirty and should be cleaned. During an interview on 6/22/23 at 9:44 a.m., director of ancillary services stated housekeeping cleaned and disinfected wheelchairs after a resident discharged and the night shift nurses would clean wheelchairs when needed. During an interview on 6/22/23 at 10:08 a.m., administrator stated the facility did not have a cleaning schedule for wheelchairs but housekeeping would clean wheelchairs after a resident discharged and the night shift nurses would clean wheelchairs when needed. Administrator confirmed R12's wheelchair was dirty and should be cleaned. A facility policy for wheelchair cleaning was requested but administrator stated the facility did not have a policy. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

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