DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2023

Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

RE: CCN: 245500
Cycle Start Date: March 8, 2023

Dear Administrator:

On May 17, 2023, we notified you a remedy was imposed. On May 4, 2023 the Minnesota Department(s) 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 April 28, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 8, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 27, 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 June 8, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 28, 2023, 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 Therefore, the NATCEP prohibition is rescinded.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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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March 27, 2023

Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

RE: CCN: 245500
Cycle Start Date: March 8, 2023

Dear Administrator:

On March 8, 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 June 8, 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 September 8, 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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
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
	245500	A. BUILDING _____ B. WING _____	C 03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(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 3/6/23, through 3/8/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location	E 041		3/15/23

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

Electronically Signed | 04/05/2023

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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E 041	Continued From page 1 requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD	E 041		

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E 041	Continued From page 2 or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interivew and document review, the facility failed to test and inspect the generator per	E 041	Disclaimer	

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E 041	Continued From page 3 NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.3 and 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1 through 8.4.2, 8.4.2.3, 8.4.9 and 8.4.9.5.1. This had a potential to affect all residents residing in the faiclity. Findings include: On 3/7/23, between 9:15 a.m. and 1:45 p.m. the available emergency generator test and inspection documentation was reviewed with the director of environmental services (DES). The facility could only provide 44 of 52 weekly emergency generator inspections for the their Station 3 natural gas generator and could only provide 46 of 52 weekly emergency generator inspections for the their Main Diesel generator. In addition, the facility was unable to provide evidence identifying the facility was running their generator at 30% of its load during the monthly testing or having an annual load bank test completed. During the review the DES verified the deficient findings at the time of discovery.	E 041	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. E041 SS=F On 3-14-23 the diesel generator was tested by technician in a 4 hour load test at 80%. Meeting requirements. On 3-15-23 the natural gas generator was tested by technician in a 4 hour load test at 90%. Meeting requirements. Weekly generator test procedure has been revised and simplified now incorporating and standardized time and the use of the recommended test form. All residents are at risk of possible harm stemming from non-functional generators in the event of an emergency. Weekly generator test procedure has been revised and simplified now incorporating and standardized time and the use of the recommended test form. Environmental services director has	

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E 041	Continued From page 4	E 041	revised workflow to ensure follow up with generator technician to ensure that scheduled tests are completed. Audits of generator inspection logs to be performed by Environmental services director or designee monthly for 3 months. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action. Corrected by 3-15-23	
F 000	INITIAL COMMENTS On 3/6/23, through 3/8/23, 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 complaint was reviewed: H5500101C (MN81235) with a deficiency issued at F686. The following complaint was reviewed with no deficiency cited: H5500102C (MN80221) 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. Upon receipt of an acceptable electronic POC, an	F 000		

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F 000	Continued From page 5 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene/ and glove use was maintained during dressing change of a pressure ulcer to prevent infection for 1 of 3 resident (R52) reviewed with pressure ulcers Findings include: R52's significant change Minimum Data Set dated 1/30/23, identified R52 had intact cognition, and was at risk for pressure ulcers. R52 has no current pressure ulcers and was on a turning and repositioning program. R52 was receiving hospice services. Diagnoses identified were "medically complex conditions" including cancer.	F 686	F686 SS=D Effected resident on hospice passed 2 days after survey ended due to unrelated issues. There was not any additional dressing changes after survey exit. All nursing staff re-educated on policy and procedure related to dressing changes one on one by DNS or designee by 04-06-2023. With focus on hand hygiene and its relationship to unwanted infection. Particularly the importance of hand hygiene between glove changes was addressed. All residents with wounds are at risk of	4/28/23

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F 686	Continued From page 6 The facility Matrix completed by the facility upon entrance to the facility on 3/6/23, identified R52 had a stage 3 pressure ulcers (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) R52's undated Order Summary report identified a order for " wound care coccyx and right buttocks. Apply a small amount of Triad cream to wound bed only, cover with adhesive dressing every two days", with a start date of 2/24/23. R52's care plan dated 3/2/23, identified R52 had a pressure ulcer on the on coccyx. Interventions included the following: Reposition resident every hour from right to left (avoid resident laying on his back, Monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider. R52's wound notes identified the following: - 2/22/23 identified, a sacral wound measuring 1.5 centimeters (cm) x 1.5 cm x 0.1 cm. There was a new open area on coccyx that was not present during the day shift. Area was red with a slight split in the skin. Upon re-check with more staff to assist with rolling it was noted that this area is now open. Resident refuses to reposition and slides down in the bed. Resident refuses to have the leg area of the bed up to prevent slipping down. Resident was very difficult to turn as R52 was pushing back so measurements and assessment are limited at this time.	F 686	infection being spread to the wound due to improper hand hygiene during wound care. DNS or designees with observe, reeducate, and audit going forward to ensure reeducation is enforced and remembered. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action to maintain sustainability. Director of nursing services or designee will perform 3 audits 3 times a week for 6 weeks of wound care encounters to ensure that that proper hand hygiene is being performed. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action. Corrected by 04-28-2023	

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F 686	Continued From page 7 - 2/26/2, identified coccyx wound 2 cm x 2 cm x 0.0 cm. Due to resident refusal to reposition and continued pressure on coccyx area. -3/2/23 identified coccyx wound 1.8 cm x 1.8 cm x 0.2 cm. Pressure ulcer wound looks like the bed has slough but unable to wipe any away - 3/4/23 wound noted identified sacral wound 2 cm x 2 cm. no depth was noted. Wound bed was 100% slough. On 3/8/23, at 8:12 a.m. R52's dressing change was observed with registered nurse (RN)-A and RN-B. RN-A and RN-B both performed hand hygiene and put on gloves. R52's dressing was exposed. RN-B removed the old dressing to R52's coccyx and cleansed the pressure ulcer with saline wound spray and 4 inch (in) x 4 in. gauze. The pressure ulcer was measured and was 1 cm x 1.5 cm., the pressure ulcer had minimal drainage and lacked and signs and symptoms of infection. The was no redness of the skin around the wound and it was intact. RN-B did not remove their gloves and perform hand hygiene. With contaminated gloves RN-B proceeded to place Triad ointment on the wound bed of the pressure ulcer and then covered the pressure ulcer with a Mepilex 3 in x 3 in foam bordered dressing. During interview on 3/8/23, at 8:31 a.m. RN-B stated she should have removed her gloves and performed hand hygiene after measuring the pressure ulcer and prior to using the cream and placing the clean dressing, to prevent cross contamination. The pressure ulcer was not currently infected and hospice had started an	F 686		

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F 686	Continued From page 8 antibiotic for preventative measure. The pressure ulcer had no signs and symptoms of infection. The facility's Wound Dressing Change policy dated 11/2/22, identified during a dressing change staff were to; 1. Perform hand hygiene and put on gloves. 2. Removed soiled dressing and discard. 3. Remove dirty gloves, perform hand hygiene, and put on clean gloves. 4. Assess and measure the wound, then cleanse the wound as ordered. 5. Remove dirty gloves, perform hand hygiene, and put on clean gloves. 6. Apply new dressing to the wound and adhere in place. 7. Clean up work area, remove dirty gloves and perform hand hygiene.	F 686		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in accordance with physician orders without errors for 1 of 10 residents (R17) observed to receive medication during the survey. A total of 2 or 25 opportunities were in error resulting in a facility medication error rate of 8 % (percent). Findings include:	F 759	F759 SS=D Medications for the resident were reordered and the resident's physician was contacted, and they directed that no changes in medications should be made and the next dose should be given as normal. The next dose was given appropriately. All nurses and TMAs re-educated on policy and procedure	4/28/23

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	245500	A. BUILDING _____ B. WING _____	C 03/08/2023

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F 759	Continued From page 9 R17's quarterly Minimum Data Set dated 2/27/23, identified R17 had diagnoses that included renal insufficiency, diabetes mellitus and osteoarthritis. R17 's physician orders dated 2/28/22, included orders for the following: levothyroxine 112 micrograms (mcg) mouth (po) daily, losartin 25 milligram (mg) 1/2 tablet po daily, omeprazole 40 mg po daily, furosemide 40 mg po daily, sennosides-docusate tablet 8.6 mg-50 mg daily, vitamin D3 1000 international units (iu) daily, potassium 20 milliequivalents (meq) 1 tab po twice a day and magnesium oxide 400 mg po twice a day. On 3/8/23, at 7:56 a.m. registered nurse (RN)-C was observed to set up R17's morning medications for administration. RN-C set up the following medications levothyroxine 112 mcg, losartin 25 mg 1/2 tablet , omeprazole 40 mg, furosemide 40 mg, sennosides-docusate tablet 8.6 mg-50 mg daily, vitamin D3 1000 international units (iu) daily. RN-C did not set up the magnesium oxide 400 mg or potassium 20 meq's. RN-C stated the magnesium and potassium were not available to administer and she would need to call the pharmacy. Due to both medication being ordered for twice a day R17 would miss her morning dose and would be a medication error. During an interview on 3/8/23, at 3:55 p.m. the director of nursing (DON) stated when a resident was due for a medication and it was not available the nurse would be expected to call the pharmacy to receive the medication. If the resident was not going to receive their medication in a timely manner, the nurse would be expected to check	F 759	related to missing one on one by DNS or designee by 04-06-2023. With focus on the steps to attain a replacement education All residents who take medications are at risk of negative outcomes, which could include harm, due to medications not being given as prescribed. DNS or designees with observe, reeducate, and audit going forward to ensure reeducation is enforced and remembered. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action to maintain sustainability. Director of nursing services or designee will perform 3 audits 3 times a week for 6 weeks of medication passes ensure that that all medications are being given in the allotted time. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action. Corrected by 04-28-2023	

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F 759	Continued From page 10 the emergency medication kit to see if a dose was available. If a dose was not available, a call would be expected to be made to the provider to inform them of the missed dose and to check if any follow up needed to be done. The facility's policy Medications: Acquisition, Receiving, Dispensing, and Storage dated 3/2/23, identified if a medication was not available from the pharmacy, the facility would need to contact the prescriber to determine if a different medication was needed or to determine the time frame acceptable to wait for the medication.	F 759		

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	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**03/07/2023**

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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. At the time of this survey, Good Samaritan Society-Bethany was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the NFPA 101 (2012 edition), Life Safety Code, Chapter 19 Existing Health Care, and the NFPA 99 (2012 edition), 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/04/2023

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 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. The facility was inspected as one building. Good Samaritan Society-Bethany is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1969, is 1-story, and was determined to be of Type II(000) construction. In 1974, two 1-story additions were constructed, one to the southwest and one to the east side of the original building, that were determined to be of Type II(111) construction and are separated with 2-hour fire barriers from the existing building. In 1980 a 1-story addition was	K 000		

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K 000	Continued From page 2 constructed to the south and east of the 1974 south addition, which was determined to be of Type II(111) construction, and is separated with a 2-hour fire barrier. In 1983 a small 1-story connecting link was added to the south of the 1980 addition to connect the facility to an apartment building and was determined to be Type V(000) construction. This link is not separated from the facility, but a 2-hour fire barrier is between the link and the apartment building. In 1994 the Physical Therapy 1- story addition was added to the north of the original building and was determined to be Type II (111) construction. In 1998 a 1-story addition was constructed to the north of the 1960 building and in 1974, an addition that was determined to be of Type V(111) construction and is separated by a 2-hour fire barrier. The main level is divided into 11 smoke zones by 30 minute and 90-minute fire barriers. The entire building is protected by a complete automatic fire sprinkler system and also has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system, in common areas, and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 76 beds and had a census of 60 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		4/28/23

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K 321	Continued From page 3 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 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 storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.7.1.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 321	Disclaimer 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	

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K 321	Continued From page 4 On 03/07/2023 at 12:00 PM, it was revealed by observation that resident rooms 303, 306, 309, 311, 313, 324, 333 and 334 did not have door closers and were being used as combustible storage rooms. An interview with the administrator verified these deficient findings at the time of discovery.	K 321	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. K321 SS=F Of the eight storage rooms without door closers, five had stored items removed from them and the other three will have closers added to them by 04-28-2023, bringing them up to code. Failure to maintain hazardous storage room doors per NFPA 101 could have an impact on all residents within the facility. The Environmental services director modified workflow to include ensuring that any resident rooms that are used for storage are inspected to ensure that door closers are installed. The Environmental services director or designee with will audit all resident rooms to ensure that any used for storage have door closers installed monthly for 3 months. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		3/15/23

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K 918	Continued From page 5 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 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 a review of available documentation and staff interview, the facility failed to test and	K 918	K918 SS=F	

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K 918	Continued From page 6 inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.4.4.1.1.3 and 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.1 through 8.4.2, 8.4.2.3, 8.4.9 and 8.4.9.5.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1) On 03/07/2023 between 9:15 AM and 1:45 PM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Director of Environmental Services, that the facility could only provide 44 of 52 weekly emergency generator inspections for the their Station 3 natural gas generator. 2) On 03/07/2023 between 9:15 AM and 1:45 PM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Director of Environmental Services, that the facility could only provide 46 of 52 weekly emergency generator inspections for the their Main Diesel generator. 3) On 03/07/2023 between 9:15 AM and 1:45 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they have been running their generator at 30% of its load during the monthly testing or having had an annual load bank test completed. An interview with the Director of Environmental	K 918	On 3-14-23 the diesel generator was tested by technician in a 4 hour load test at 80%. Meeting requirements. . On 3-15-23 the natural gas generator was tested by technician in a 4 hour load test at 90%. Meeting requirements. Weekly generator test procedure has been revised and simplified now incorporating and standardized time and the use of the recommended test form. All residents are at risk of possible harm stemming from non-functional generators in the event of an emergency. Weekly generator test procedure has been revised and simplified now incorporating and standardized time and the use of the recommended test form. Environmental services director has revised workflow to ensure follow up with generator technician to ensure that scheduled tests are completed. Audits of generator inspection logs to be performed by Environmental services director or designee monthly for 3 months. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action.	

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K 918	Continued From page 7 Services verified these deficient findings at the time of discovery.	K 918		