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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O4KV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00303

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245455**

2.STATE VENDOR OR MEDICAID NO.
(L2) **673342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - JACKSON**
(L4) **601 WEST JACKSON**
(L5) **JACKSON, MN** (L6) **56143**

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/24/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 06/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 06/24/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 24, 2021

CMS Certification Number (CCN): 245455

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 4, 2021 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

An equal opportunity employer.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 24, 2021

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: CCN: 245455
Cycle Start Date: April 29, 2021

Dear Administrator:

On June 21, 2021, 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, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O4KV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00303

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245455**

2.STATE VENDOR OR MEDICAID NO.
(L2) **673342500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - JACKSON**
(L4) **601 WEST JACKSON**
(L5) **JACKSON, MN** (L6) **56143**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/29/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **53** (L18)

13.Total Certified Beds **53** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Kari Witte, HFE NE — 06/14/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 06/24/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Please disregard previous letter posted on 5/20/21. The Health and Life Safety Code surveys are now both included in the same enforcement cycle.

Electronically delivered
May 26, 2021

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: CCN: 245455
Cycle Start Date: April 29, 2021

Dear Administrator:

On April 29, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 July 29, 2021 (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 October 29, 2021 (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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

PLEASE NOTE THAT THE HEALTH AND LIFE SAFETY CODE SURVEYS WILL BE PROCESSED IN SEPERATE ENFORCMENT CYCLES.

Electronically delivered
May 20, 2021

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: CCN: 245455
Cycle Start Date: April 29, 2021

Dear Administrator:

On April 29, 2021, 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.

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- 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 July 29, 2021 (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 October 29, 2021 (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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	245455	A. BUILDING _____ B. WING _____	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON JACKSON, MN 56143**

(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 4/26/21 - 4/29/21, 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) (e) Emergency and standby power systems. The [LTC facility and the CAH] 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), §485.625(e)(1) Emergency generator location. The generator	E 041		5/28/21

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

Electronically Signed | 05/28/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING _____ B. WING _____	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON JACKSON, MN 56143**

(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 041	Continued From page 1 must be located in accordance with the location 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) 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) 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), 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 or at the National Archives and Records Administration (NARA). For information on the	E 041		

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	245455	A. BUILDING _____ B. WING _____	C 04/29/2021

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E 041	Continued From page 2 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 interview and document review, the facility failed to maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2012	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	

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E 041	Continued From page 3 edition (LSC) sections, 9.1.3 and NFPA 110 "Standard for Emergency and Standby Power Systems 6-4, 6-4.1, and 6-4.2.2. This deficient practice had the potential to affect the safety of 39 residents, staff, and visitors. Findings Include: During a facility tour between 9:30 AM and 12:30 PM on 4/28/21, observations, staff interview, and documentation reviewed revealed the following: During the walk-through inspection of the facility and review of documentation, the install date of the facility's emergency generator battery was greater than 2 years since previous replacement. This deficient practice was confirmed by the administrator at the time of discovery.	E 041	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. E 041 1. The Life Safety Code requirements for emergency generator battery timeframes were addressed with the environmental services director immediately and a new battery was installed 5/24/21. 2. This has the potential to affect all residents. 3. Administrator provided re-education for the environmental services director on NFPA 101 and NFPA 110 on 5/28/21. The Tels program has been updated on 5/24/21. 4. The environmental services director/designee will perform generator audits weekly ongoing. Results will be brought to the monthly quality committee for further recommendations. Date of correction 5/28/21	

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F 000	Continued From page 4	F 000		
F 000	INITIAL COMMENTS On 4/26/21 - 4/29/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED H5455017C (MN67002), H5455019C (MN66781), H5455020C (MN63721) however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints was found to be UNSUBSTANTIATED: H5455018C (MN55245) 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		5/28/21

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F 677	Continued From page 5 by: Based on observation, interview and document review, the facility failed to provide nail care for 1 of 1 resident (R2) who was dependent on staff for assistance with grooming and personal hygiene. Findings include: R2's facesheet printed on 4/29/21, indicated diagnoses that included vascular dementia without behavioral disturbances. R2's quarterly Minimum Data Set (MDS) assessment dated 1/20/21, indicated R2 had severe cognitive impairment, had adequate hearing and vision, clear speech, usually understood others and was sometimes understood. R2 was dependent upon staff for bed mobility, transfers, walking, dressing, toileting and hygiene. R2's plan of care, printed on 4/29/21, indicated R2 had an activity of daily living (ADL) self-care deficient related to dementia, with functional and cognitive deficiencies. In addition, the care plan indicated R2 needed assistance of one staff for personal hygiene; however refused cares such as shaving, oral care and changing into clean clothes. Furthermore, R2's care plan indicated he had a history of scratching his arms, hands and legs and staff were to keep his fingernails short. During an observation on 4/26/21, at 6:11 p.m., while in bed, R2's fingernails on both hands were noted as being long and some nails were jagged. Fingernails appeared to have dark material under the nails. R2 was not able to unable to answer questions about his nails.	F 677	F677 1 – R2's nails were cleaned and trimmed by 5-24-21. 2 – All residents were checked to ensure their nails were clean and trimmed by 5-28-21. 3 - All nursing staff will be provided with reeducation by the DON or designee on the facility policy and procedure for grooming and hygiene as it pertains to Nail Care. Education will include reporting to the nurse if resident refuses nail care by 5-28-21 4 - Proper nail care will be audited by DON/Designee Every week times 4 weeks then Every month times 3 months Results will be taken to monthly QAPI meetings for further recommendations.. Date of correction - 5-28-21	

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F 677	Continued From page 6	F 677		

During an observation and interview on 4/28/21, at 8:11 a.m., R2 was up in a wheelchair in his room, waiting for breakfast. Fingernails unchanged from 4/26/21, still long, jagged and dirty. When asked if he would like his nails trimmed, R2 stated he liked them long. R2 also stated he can self-propel himself to the dining room, but according to his MDS, required assistance of one. At 8:16 a.m., a nursing assistant (NA) came to R2's room to wheel him to the dining room.

Progress notes dated 4/28/21, at 10:56 p.m., indicated R2 "refused bath." No mention of attempts to clean and/or trim nails.

During an interview on Thursday 4/29/21, at 9:47 a.m. NA-D stated R2's bath day was Wednesday evening. When asked if R2 had a bath last evening; NA-D looked in the NA documentation portion of the electronic medical record (EMR) and stated he did have a bath but could not verify if his nails were also cleaned and trimmed. NA-D stated she personally trimmed resident nails after their baths so they were nice and soft. Together looked at R2's nails and NA-D stated "they should have been trimmed, they're long."

During an interview on 4/29/21, at 9:50 a.m., licensed practical nurse (LPN)-A stated R2 received bed baths as he was resistive to tub baths. Together looked at R2's nails and LPN-A stated to R2 "you need a good manicure."

During an interview on 4/29/21, at 11:13 a.m., the director of nursing (DON) stated R2's nails were to be checked, cleaned and trimmed with every bath ... even a bed bath. DON added, if he refused to have his nails trimmed, staff needed to

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F 677	Continued From page 7 document this. DON stated NA's were able to trim resident nails, but if the resident refused, she expected them to tell the nurse. Facility policy titled Restorative, Grooming-Rehab/Skilled, dated 6/26/20, indicated: 1. Staff to assist the resident to complete grooming activities, including grooming of nails. 2. The purpose of grooming is to assist the resident to achieve optimum level of independent function with dignity to improve feelings of self-worth. 3. Use positive and reassuring approach. 4. Suggest changes with a gentle, firm approach when corrections are needed. 5. Policy included step by step nail grooming instructions for staff.	F 677		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and	F 693		5/28/21

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F 693	Continued From page 8 services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide appropriate gastrostomy tube flushing to prevent complications for 1 of 1 resident (R19) observed during medication administration. Findings include: R19 was admitted to the facility 12/14/18, with diagnoses including: hemiplegia (paralysis of one side of the body), hemiparesis (weakness or the inability to move on one side of the body), malignant neoplasm (abnormal mass) of the brain, gastritis (inflammation of the lining of the stomach), dysphagia (difficulty or discomfort in swallowing), and a gastrostomy tube (G-tube) for nutrition. R19's quarterly minimum data set (MDS) assessment dated 2/24/21, identified R19 with no cognitive impairment, required total assistance with activities of daily living (ADL), and received nutrition via a feeding tube R19's orders dated 9/9/20, indicated flush with 30 cc (cubic centimeter) of sterile water before medications, 5 cc between medications and 30 cc after all medications. Document total number of cc used. On 4/27/21, at 12:30 p.m. licensed practical nurse (LPN)-A entered R19's room with supplies for	F 693	F 693 1 - Sterile water was purchased for use with medication administration and flushes with medication. Policy and procedure for amount of sterile water to be used with crushed medication and amount to be used to flush between each medication given has been reviewed with RN/LPNs. 2 -All residents with a gastrostomy tube will be identified and orders reviewed to ensure sterile water in the appropriate amount is being used for Medication administration and flushes before and after administration by 5-28-21. 3 – Education on facility policy and procedure for medication administration and flushes will be provided to all licensed staff by the DON/designee by 5-28-21. 4 - DON/designee will audit use of sterile/purified water with medication administration and amount of sterile/purified water to be used in flushes between medications Weekly X 4 weeks then Monthly X 3 months then Results will be taken to monthly QAPI meetings for further recommendations. Date of correction – 5-28-21	

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F 693	Continued From page 9	F 693		

medication administration. LPN-A donned gloves, then used a syringe with air and a stethoscope to check placement of R19's gastrostomy tube. LPN-A then filled the syringe with 15 cc (cubic centimeters) of water, then flushed R19's tubing with the water. LPN-F failed to follow physician order and only provided R19 with 15 cc of water via syringe into the gastrostomy tube prior administering medications. LPN-A added water to the first medication cup containing medication and administered the medication by syringe into R19's gastrostomy tube. LPN-A administered two more medications in same manner for R19 while flushing between each medication with 5 cc. LPN-A then filled the syringe with 15 cc of water, then flushed R19's tubing with the water. LPN-A failed to follow physician order and only provided R19 with 15 cc of water via syringe into the gastrostomy tube after all medications were administered.

On 4/29/21, at 1:06 p.m. LPN-A confirmed not flushing R19's G-tube with 30 cc of water prior or after administering medications on 4/27/21. LPN-A further confirmed her usual practice was to flush the G-tube with 30 cc of water before and after administering medications as ordered.

On 4/28/21, at 2:14 p.m. director of nursing (DON) indicated it would be her expectation for nursing staff to provide consistent care, which should include prior flushing before medications administered, between medications given, and after medication administration as ordered by the physician. The DON indicated she would expect nursing staff to follow R19's physician orders.

The facility policy titled Medication: Tube Administration-Rehab/Skilled dated 2/10/21

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F 693	Continued From page 10 indicated: - Purified or sterile water is recommended for all preparation and administration of medication due to the risk of undesired molecular combinations that could occur with crushed medications and impure water. Policy/Procedure 1. Verify physician's order. 6. Flush tube with 30 (cc) of purified or sterile water before and after administering each medication pass.	F 693		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		5/28/21

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F 755	Continued From page 11 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for periodic reconciliation of controlled or narcotic medications in 1 of 1 emergency kit (E-Kit) and 3 of 3 refrigerators to prevent potential loss or diversion. This had the potential to affect any of the 39 residents present in the facility who may require controlled medications from the E-Kit and refrigerators. Findings include: On 4/26/21, at 6:40 p.m. a tour of the north unit medication room was conducted with licensed practical nurse (LPN)-B. Located within the medication room was a locked cabinet with an E-Kit. The E-kit was observed to have an unsecured green tag present and included lorazepam (an anti-anxiety medication/controlled substance), morphine (narcotic pain medication/controlled substance), diazepam (an anti-anxiety medication/controlled substance), and hydrocodone (a narcotic pain medication/controlled substance). LPN-B indicated if the E-Kit was opened and medications were removed, nursing staff would remove the red tag (which locked the E-Kit) and replaced with a green tag to secure the E-Kit until the pharmacy came to change out the E-Kit. LPN-B was unsure how often pharmacy came to	F 755	F755 1 &2 Medications in the affected refrigerator were destroyed. New medications were obtained and are being stored in a different refrigerator and are being monitored for appropriate temperature. E-Kit was reconciled on 4-30-21. 3. DON or designee will provide re-education for all nursing staff on reconciling and documenting the E-kit every shift change following the GSS policy and procedure for reconciling medications/E-kits on 5-28-21. Medication refrigerator temps are being monitored and recorded twice a day to ensure appropriate temps are maintained. Nursing staff have been provided with education on procedures for monitoring med refrigerator temps, documenting and notifying if temps are not within appropriate range. Refrigerated E-kit medications will be reconciled at shift change. 4 DON or designee will audit refrigerator temps and E-kit reconciliation procedure Weekly X 4 weeks then Monthly X 4 weeks then Results will be taken to monthly QAPI	

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F 755	Continued From page 12 the facility. LPN-B confirmed being aware the E-kit included lorazepam, hydrocodone, morphine, diazepam and further confirmed nursing staff did not include the narcotic contents from the E-Kit with their narcotic counts. LPN-B stated when medications were removed from the E-kit, pharmacy was notified and would bring a new E-kit to replace the opened one. LPN-B confirmed three of the hydrocodone were removed from the E-kit last week and were signed out by LPN-B and another nurse and further confirmed the contents of the E-kit had not been reconciled since. The tour further indicated two medication refrigerators on north unit to contain a 2 mg lorazepam vials located in each refrigerator and LPN-B confirmed the lorazepam was not being reconciled. On 4/26/21, at 7:02 p.m. the director of nursing (DON) confirmed the E-kit should be restocked by pharmacy the next day when medications are removed. The DON further confirmed the E-Kit should be locked and reconciled daily. On 4/28/21, at 12:00 p.m. the south medication room refrigerator was observed with licensed registered nurse (RN)-A and included a vial of lorazepam. RN-A could not find documentation the lorazepam was reconciled daily, though stated previously nursing staff had been reconciling. The policy titled, Medications: Controlled Medication Storage, dated 12/11/2020, included: 3. Each time the keys that secure controlled medications change from one nurse/medication aide to another, the oncoming an off-going nurse/medication aide will work together to reconcile all controlled medications, including all	F 755	committee for further recommendations. Date of correction □ 5-28-21	

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F 755	Continued From page 13 discontinued controlled medications and document the same. 4. The access system used to lock controlled medications cannot be the same access system used to lock non-controlled medications. 5. Controlled medications needing refrigeration will be double locked in a permanently affixed compartment within the medication refrigerator. For all schedule II-controlled medications -1. The nurse going off shift unlocks a controlled medication storage unit(s) and will then go to the narcotic count book and read each GSS # 247 page to the on-coming nurse. The on-coming nurse will verify that the physical medication count matches the remaining amount listed in the GSS#247 for each medication. Controlled medications that have been discontinued should be placed in a lock box in the medication room as soon as they have been discontinued, or as indicated by state regulation. Controlled medications should continue to be counted by two nurses until disposal is completed.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		5/28/21

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F 758	Continued From page 14 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) of a psychotropic medication was attempted or rationale provided for current dose	F 758	F758 1 – R18's Provider reviewed and re-ordered Lorazepam and Haldol for agitation for an additional 14 days on	

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F 758	Continued From page 15 justification for 2 of 5 residents (R18, R25) reviewed for unnecessary medication use. In addition the facility failed to identify specific parameters for use of an antipsychotic medication for 1 of 5 residents (R18) reviewed. Findings include: R18's Face Sheet printed 4/28/21, indicated diagnoses including: Alzheimer's disease, major depressive disorder, panic disorder, dementia, and wandering. R18's quarterly Minimum Date Set (MDS) assessment dated 2/18/21, indicated resident had moderately impaired cognition, and exhibited behavioral symptoms not directed toward others daily. The MDS further indicated R18 experienced delusions and wandered 4-6 days, but less than daily during the assessment period. R18's physician orders dated 5/31/19, included: lorazepam 0.5 milligrams (mg) give one tablet orally every six hours as needed for agitation. R18's physician ordered dated 4/12/21, indicated haloperidol (anti-psychotic) 5 mg intramuscular (IM) every eight hours PRN (as needed) for agitation. The order did not include specific parameters for use. The MAR (medication administration record) dated April 2021, indicated Haldol was administered on 4/12/21 and 4/22/21 and documented to be effective on the MAR. Review of R18's medical record did not include evidence the physician had reviewed the continued use of the prn haloperidol (Haldol)	F 758	5-27-21. Nonpharmacological interventions will be attempted prior to giving these medications as directed by the care plan. R25's provider reviewed order for Citalopram on 5-5-21 and reduced the dose to 10mg. A referral has been made for Meditelecare behavioral health services to see both R18 and R25. 2 – Consultant Pharmacist and DON will review all PRN psychoactive medications for rationale and non-pharmacological interventions to be used before medication use by 5-28-21. 3 – DON or designee will provide re-education to all nursing staff and providers on GSS policy and procedure and regulations for use of psychotropic medications. This will include use of non-pharmacological interventions and documentation of them….. 4 – DON or designee will audit psychoactive medication use, orders and rational for use to ensure policy and procedure and regulations are followed. Weekly X 4 then Monthly X 3 then Results will be taken to monthly QAPI meeting for further recommendations. Date of correction – 5-28-21	

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F 758	Continued From page 16 within 14 days of ordering. Interview on 4/27/21, at 1:36 p.m. the director of nursing (DON) confirmed the physician had not reviewed R18's medications since 4/12/21. The DON confirmed R18's PRN Haldol had not been re-evaluated within 14 days since ordered on 4/12/21. Review of R18's current plan of care printed 4/28/21, did not include the use of Haldol and did include any monitoring of target behaviors or side effects/adverse reactions related to the Haldol use. On 4/27/21, at 2:31 p.m. licensed practice nurse (LPN)-B confirmed administering R18's Haldol only when the resident was unable to redirect and behaviors included hitting, yelling, pacing, and aggressiveness. LPN-B further confirmed other interventions were implemented prior to the Haldol, including attempts to administer PRN lorazepam, which the resident refused. LPN-B verified the PRN Haldol was not to be administered unless the resident exhibited severely aggressive behaviors. The policy titled, Psychotropic Medications-Rehab/Skilled dated 11/19/20 included: While the use of PRN psychotropic medications is not encouraged, if a PRN physician's order is received, ensure that the order has clear parameters, i.e., severe agitation that does not respond to other care plan interventions. It is important to initiate other care plan interventions prior to the use of prn psychotropic medications. PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing	F 758		

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F 758	Continued From page 17	F 758		

practitioner believes that is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the residents' medical record and indicate the duration for the PRN order. PRN orders for anti-psychotic drugs are limited to 14 days.
R25

R25's Face Sheet printed 4/28/21, indicated an admission date of 2/16/2018, with diagnosis including hemiplegia and hemiparesis following cerebral infarction (stroke), and mood disorder due to known physiological condition with depressive features.

R25's quarterly Minimum Data Set (MDS) assessment dated 3/21/21, indicated R25 is rarely understood and rarely understands, has severe cognitive dysfunction, and has no signs of depression on a staff scored "Patient Health Questionnaire" (PHQ-9) used to determine severity of major depressive disorders.

R25's care plan dated 3/5/18, identified R25 has a mood problem related to depression and to consult with pharmacy, heath care provider and family to consider dosage reduction when clinically appropriate.

R25's progress notes dated 8/17/20, indicated a consultant pharmacist (CP) recommendation, which included Citalopram gradual dose reduction is due for review. A second consultant pharmacist recommendation note dated 10/2/20, stated prescriber made no change in Citalopram dose, please see form for rationale.

A form titled "Consultant Pharmacist Communication to Physician" dated 9/18/20

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stated R25 required an antidepressant gradual dose reduction attempt and provider was to select "I agree" with written orders, or "other" and to please write a brief statement concerning the rationale for response to this recommendation. The provider responded to please continue current dosage dated 10/2/20, which lacked a rationale for continuing Citalopram 20 mg every day.

R25's Order Summary Report dated 9/8/2020, indicated R25 had a physician order for Citalopram 20 mg once a day for mood disorder.

R25's Order Summary Report dated 4/28/21 indicated R25 remained on Citalopram 20 mg tablet once a day for mood disorder.

During interview on 4/28/21, at 11:45 a.m., registered nurse (RN)-B indicated the provider does not follow direction and RN-B has explained how to complete the forms but he just doesn't do it. RN-B indicated she did not attempt to send it back for a rationale after receiving the form. RN-B confirmed there was no dose reduction or rationale provided.

During interview on 4/28/21, at 1:36 p.m., the director of nursing (DON) confirmed there was no rationale provided or documented to continue the Citalopram 20 mg tablet daily.

A facility policy titled "Pharmaceutical Services" dated 6/17/20, indicated pharmacy services will be available at all times. These services will be provided to meet the needs of each resident including...administering of all medications and biological's.

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F 761	Continued From page 19	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe medication refrigerator temperatures were maintained in 2 of 2 nursing units (north and south) to ensure medication efficacy. This had the potential to affect all 39 residents. Findings include:	F 761	F 761 1 &2– All medication in refrigerator was replaced and new refrigerator was ordered. All meds are stored in the North refrigerator which is the proper temperature. 3 – LPN/RN were reeducated on checking temperatures of all nurses stations refrigerators and freezers twice every day	5/28/21

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F 761	Continued From page 20 On 4/26/21, at 7:02 p.m. during observation of the north unit medication room with licensed practical nurse (LPN)-B the medication refrigerator temperature log was reviewed and revealed the medication refrigerator was to be maintained between 36-46 degrees Fahrenheit (F). LPN-B confirmed there were temperatures out of range and no action was taken for the out-of-range temperatures. The medications in the south medication fridge included lorazepam 2 milligram (mg) vial, Novolog vial (insulin), insulin pen, and tuberculin. The April 2021 log for the north medication indicated the following temperatures were not within range: 4/3/21, 30 degrees F. 4/7/21, 30 degrees F. 4/17/21, 30 degrees F. 4/19/21, 28 degrees F. 4/20/21, 30 degrees F. 4/22/21, 34 degrees F. 4/24/21,32 degrees F. Interview on 4/28/21, at 9:07 a.m. with the director of nursing (DON) confirmed she received the refrigerator readings each month to review. The DON confirmed she reviewed March 2021 logs for the north and south medication refrigerators and verified there were temperatures out of range. The DON further confirmed she did not act on the out-of-range temperatures. The DON stated she would expect the nursing staff to notify her when the medication refrigerator temperatures were out of range and she would notify maintenance. The DON confirmed she should have acted on the out-of-range temperatures when she reviewed the temperature logs at the end of the month.	F 761	and to alert DON/designee if temperature is out of range. 4 – DON/designee will audit refrigerator and freezer temperatures Weekly X 4 then Monthly X 3 then Results will be reported to monthly QAPI meetings for further recommendations. Date of correction – 5-28-21	

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F 761	Continued From page 21	F 761		

On 4/28/21, at 10:00 a.m. observed the south unit medication room with registered nurse (RN)-A; the refrigerator temperature documentation was posted on the front the of refrigerator for April 2021. The refrigerator medications included pantoprazole liquid suspension, acetaminophen suppositories, insulin 70/30, insulin pen, and lorazepam vial. RN-A stated when she noted the temperature to be at 32 degrees or below, she would adjust the fridge's temperature dial.

The April 2021 log for the south medication indicated the following temperatures were not within range:

4/2/21, 30.8 degrees F
4/3/21. 32.9 degrees F
4/85/21, 29.7 degrees F
4/7/21, 29 degrees F
4/9/21, 28.1 degrees F
4/13/21, 25.4 degrees F
4/14/21, 24.8 degrees F
4/15/21, 20.9 degrees F and 33.0 degrees F
4/16/21, 20.9 degrees F and 26.5 degrees F
4/18/21, 21.2 degrees F
4/19/21, 25.6 F degrees and 22.9 degrees F
4/20/21, 26.8 degrees F
4/22/21, 24.1 degrees F
4/24/21, 23.6 degrees F
4/27/21, 23.2 degrees F
4/28/21 28.4 degrees F

Interview on 4/28/2, at 10:56 a.m. interview with the consulting pharmacist stated the medication refrigerators should remain between 36-46 degrees. The pharmacist indicated temperatures below 36 degrees break down the insulin, and the temperature of the insulin should remain between 36-46 degrees. The pharmacist confirmed if the

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refrigerator temperatures were not within range the insulin and other medications should not be used. The pharmacist further confirmed the insulin and other medications would not be as effective for the residents. The pharmacist verified she reviewed resident's medications monthly and went into the facility quarterly. The pharmacist confirmed there had been no residents with frequent insulin adjustments. The pharmacist verified last being in the facility at the end of January 2021 and had not observed concerns with the medication refrigerator temperatures at that time.

On 4/28/21, 12:00 p.m. the south medication refrigerator was observed with the DON. The inside back of the refrigerator was observed with ice buildup. Medications in the refrigerator included pantoprazole liquid, acetaminophen suppositories, insulin 70/30, and lorazepam. The DON confirmed the bag the lorazepam vial was in contained water and condensation and could indicate the lorazepam could have previously been frozen. The insulin vial was observed with a formed particle in the vial and small formed particles floating in liquid. The DON confirmed the documented temperatures and verified 32 degrees or below was freezing.

On 4/28/21, at 2:14 p.m. the DON stated she verified the temperature of the south refrigerator with another thermometer. The DON stated both thermometers read 37 degrees and confirmed the thermometer was reading temperatures correctly. The DON stated the pantoprazole was the only medication opened and used for R19. The pantoprazole was dispensed 4/21/21 and the other medications were not opened or used.

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On 4/29/21, 9:48 a.m. maintenance supervisor (MS)-A stated he was not aware of any issues with the refrigerators and staff had not discussed any issues with the temperatures of the refrigerators. MS-A confirmed a maintenance book was located in the nursing station for staff to utilize and record maintenance concerns. The book was observed to have no concerns related to the refrigerators. MS-A further confirmed staff would also put a note on his door related to equipment concerns and he had not received any notes from staff related to the refrigerator.

On 4/28/21, at 1:30 p.m. LPN-C stated the night nurses and evening nurses were responsible to record refrigerator temperatures and verified the staff did not follow through with the expectations of reporting temperatures below 36 degrees in the medication refrigerators.

The package inserts for the Humulin 70/30:
-store not in-use (unopened) HUMULIN 70/30 vials refrigerated.
-store in a refrigerator (36° to 46°F [2° to 8°C]), but not in the freezer.
-do not use if it has been frozen.
- if stored at room temperature, below 86°F (30°C) the vial must be discarded after 31 days.

Storage for Protonix for delayed-release oral suspension included:
- 20° to 25°C (68° to 77°F); excursions permitted to 15° to 30°C (59° to 86°F).
- Do not freeze.

The document titled maintenance request sheet for the months of January 2021-April 2021 did not contain any concerns regarding the refrigerators.

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F 761	Continued From page 24 The document titled Medications: Acquisition Receiving Dispensing and Storage-Rehab/Skilled dated 12/28/20, indicated: - All medications will be stored in accordance with manufacturers' recommendations. - Refrigerators holding medications (such as insulin, etc.) will be kept between 36 degrees F and 46 degrees F. Medications rooms will be kept between 59-degree F and 29-degree F. Check refrigerator temperatures daily..	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a manner that was palatable to the residents. This deficient practice had the potential to affect all 39 residents residing in the facility who consumed food from the kitchen. Finding include: During an interview on 4/26/21, at 2:37 p.m., R12 stated the food was very bad, adding that her family brought her a refrigerator for her room so she could keep her own food to eat. R12 stated she had told "anybody who will listen [about the	F 804	F 804 1. Food and Nutrition director immediately counseled and educated the cook on proper preparation and presentation of meals. 2. This has the potential to affect all residents. 3. Dietary manager will provide education to all cooks and dietary staff on proper preparation and presentation of food. This will be followed by competency checks for the cooks to ensure meals are nourishing, attractive, and palatable while being served at a safe temperature.	5/28/21

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F 804	Continued From page 25 food] -- it's no secrete." R12 stated the dietary department was short staffed and the staff kept turning over. R12 stated the mixed vegetables were mush and cinnamon rolls on 4/25/21 were burnt on the bottom -- dry and hard -- and she could not eat the bottom of the roll. During an interview on 4/26/21, at 3:07 p.m., R7 stated the food was so bad, he got his own refrigerator and his daughter brought food in for him. R7 stated the quality of food is bad and the cooking is bad, adding he had told staff how bad it was, but nothing ever got done about it. During an interview on 4/26/21, at 6:30 p.m., R12 stated she wanted small portions, but didn't get them, even though she had told the kitchen staff. R12 stated the food is often overdone, giving an example of overdone hamburgers that were served which were hard around the edges. At the same meal, she received a cookie that was so overdone, she couldn't bite into it. R12 stated one of the staff said to her that day: "I think we're having an overdone meal tonight." During an observation in the dining room on 4/28/21, at 8:47 a.m., observed R2 and R29 had what appeared to be bacon on their plates, but it was in pieces and was dark and dry looking; it appeared overcooked. Asked certified dietary manager (CDM)-C who was in the dining room, to look at the bacon and she stated "that's overcooked; it should look pretty for the residents." In the kitchen, cook (C)-A was asked about the bacon being dark and dry. C-A stated "that's the way it comes - precooked." C-A stated the bacon was a new product. Looking at the bacon on the steam table, C-A stated "I didn't realize it was as done as it was." C-A obtained the	F 804	Dietary/food issues will be added to the Resident council agenda to solicit resident's input each month. Any concerns will be addressed and resolved by the dietary manager. 4. Observation audits of meals to ensure they are prepared and presented appropriately will be conducted by the dietary manager, or floor staff if not present, daily X 1 week then weekly X 3 then monthly X 2. Results will be brought to the monthly quality meeting for further recommendations. Date of correction 5/28/21	

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F 804	Continued From page 26	F 804		

box of bacon from the refrigerator which read: "Hormel Fast 'n Easy Bacon - Fully Cooked Rounds." Heating instructions for a conventional oven indicated to preheat to 400 degrees Fahrenheit and heat for approximately three minutes to desired crispness. C-A stated she didn't read the instructions and cooked it at 350 degrees for 15 minutes, adding "I saw it was dark, but I didn't think anything of it." Looking at bacon rounds in the steam table, C-A admitted the bacon was dry, dark and hard and should not have been served to residents. Resident R29 ate everything on his plate except the bacon, stating it was "too hard to chew."

During an interview on 4/28/21, at 9:10 a.m., R12 who was in her room, eating breakfast, stated "I don't like big portions and I've told them. I don't want their bread because I don't like the butter substitute they use; I've told them, but I still get it." Toast was observed on her plate. Stated she told this to CDM-B. "Not only is the food terrible, but it's such a waste if we can't eat it." "We look forward to the food - what else do we have to look forward to?" Observed R12's meal card on her breakfast tray; and there was nothing on it about portion sizes or her likes/dislikes.

During an observation on 4/28/21, at 11:15 a.m., C-A removed two approximately 10 inch by 12 inch foil pans of lasagna from the oven which had areas of burnt cheese on top. C-A stated "it always looks like that." The burnt cheese extended two to three inches into the center of the lasagna. CDM-C looked at it and instructed C-A to removed the burnt areas. C-A scraped it off with a rubber spatula, then added shredded mozzarella cheese over top. At 11:57 a.m., C-A removed a third pan of lasagna from the oven.

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F 804	Continued From page 27	F 804		

This pan of lasagna had a greater area of burnt cheese than the first two pans. The burnt cheese was scraped off by C-A, effectively removing the top layer of the lasagna, and added shredded mozzarella cheese. C-A stated she would not have served the burnt lasagna to residents; she would have cut around the burnt areas.

During an interview on 4/28/21, at 1:38 pm., the administrator stated CDM-B who was at the facility on 4/26/21, was no longer with the facility; she had resigned and there was a corporate CDM-C at the facility until a new CDM could be hired. Administrator was unaware of food quality concerns by residents and was informed of resident complaints about food being overcooked, and observations of overcooked bacon and burnt cheese on lasagna. The administrator stated it had been a challenge as they had been working short in the kitchen and the CDM had to work as the cook, so some things hadn't been kept up.

During document review on 4/28/21, at 3:10 pm., reviewed C-A's qualifications to work as a cook. C-A had a ServSafe Certification obtained on 10/24/18, expiring on 10/24/23. According to the administrator, C-A had a performance improvement plan in September 2019, related to quantity and portion control and sanitary environment. This was extended on 10/23/19 due to additional complaints. The administrator reiterated they were short staffed in the kitchen and there was lack of oversight of cooks because the dietary manager had to work as a cook. The administrator stated CDM-C would be at the facility until a new CDM was hired.

Facility policy titled Dining Service Standards -

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F 804	Continued From page 28 Food and Nutrition Services, dated 4/5/21, indicated: 1. Residents will be provided meals that are nourishing, attractive, and palatable and served at a safe and appetizing temperature. 2. Take into consideration each resident's individual needs and food preference. 3. Meals will be based on available resident information (e.g., resident choice/preferences, tray/diet cards).	F 804		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe and sanitary environment for residents as a result of peeling ceiling paint in the kitchen over a food preparation surface. This had the potential to affect all 39 residents residing in the facility who consumed food from the kitchen. Findings include: During an observation on 4/28/21, at 11:05 a.m., peeling paint was noted on two areas of the kitchen ceiling. The ceiling was a solid, flat surface, painted a white/cream color. Directly over a metal food preparation surface was an area of peeling paint, including a flap of paint about the size of a hand, hanging down over the work surface. On the metal work surface was a jar of peanut butter and a knife. In addition, there	F 921	F 921 1. The ceiling was spot mudded by the environmental service director to prevent any paint chips from falling on 5/25/21. 2. This has the potential to affect all residents. 3. The ceiling will be professionally repaired by 6/18/21 by Harley's Construction. 4. Audits will be conducted to ensure there is no peeling paint on the ceiling daily until professional repair is completed then weekly X 4, then monthly X 3. Results will be taken to monthly quality committee for further recommendation. Date of correction 6/18/21	5/28/21

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F 921	Continued From page 29	F 921		

was a circular area of peeling ceiling paint near the exit of the kitchen going into the dining room. This area was approximately 18-24 inches in diameter, with peeling paint around the perimeter of the circle. While this area of peeling paint was not directly above a food preparation surface, food was removed from the microwave and carried underneath it. Carts containing resident trays passed under this area also.

During an interview on 4/28/21, at 11:08 a.m., cook (C)-A was asked if she was aware of the peeling paint on the ceiling, and stated, "yeah, I seen that" and "maintenance supervisor (MS)-A knows about it." C-A was not able to say how long it had been there, and had not seen paint chips fall onto the food preparation surface.

During an interview on 4/29/21, at 11:45 a.m., the administrator was unaware of the peeling paint on the kitchen ceiling and would work with MS-A to correct the problem right away.

During a telephone interview on 4/29/21, at 11:57 a.m., MS-A stated he was aware of the peeling paint on the ceiling in the kitchen. MS-A stated there were problems with the roof and when it rained, the paint on the ceiling in the kitchen peeled. MS-A stated he had not been able to work on it due to other priorities. He is the only maintenance worker and finds it challenging to maintain the building on his own, however would work on it in the next couple of weeks. MS-A acknowledged that paint dropping into resident food or food preparation surfaces was a safety and infection control concern.

Facility policy titled Cleaning Schedule - Food and Nutrition Services, dated 3/31/21, indicated:

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F 921	Continued From page 30 1. Ceilings: check for cobwebs, dust and dirt or condensation so it cannot fall from the ceiling. 2. Ceilings were to be spot-cleaned on an as needed basis.	F 921		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/28/2021. At the time of this survey, Good Sam Society-Jackson was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/04/2021

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society-Jackson is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1956, is one-story, has no basement, and was determined to be of Type I(332) construction; The 1st Addition was constructed in 1965, is one-story, has no basement, and was determined to be of Type I(332) construction; The 2nd Addition was constructed in 1976, is one-story, has a partial basement, and was determined to be of Type	K 000		

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K 000	Continued From page 2 I(332) construction; The 3rd Addition was constructed in 1996, is one-story, has no basement, and was determined to be of Type I(332) construction. The building is divided into six smoke compartments. The building is protected by a complete 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 46 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		6/4/21

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K 353	Continued From page 3 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to maintain and test the sprinkler system in accordance with the Life Safety Code NFPA 101, 2012 edition, sections 9.7.5, 9.7.7, and 9.7.8, and NFPA 25, 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient practice could affect all 46 residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/28/2021, observations, staff interview, and documentation reviewed revealed the following: 1) During documentation review - annual and quarterly testing and inspection reports identified that the taper switch in the butterfly valve is not functional. No documentation was provided to confirm repairs had been made. 2) During the walk-through of the facility, the following was observed: a. Cables were attached to the sprinkler system in the following locations: i. Basement corridor ii. Dry Goods Storage Room iii. Dietary Storage Room b. In the Fire Sprinkler Riser room: i. There was restricted and obstructed access to the sprinkler system controls ii. A sprinkler head storage cabinet could not be located, and contents could not be assessed c. In the Kitchen walk-in cooler, the dry	K 353	Cables were removed immediately from sprinkler system, Olympic Fire fixed the butterfly valve on 5/25/21, and all obstructions were removed from the sprinkler system controls and sprinkler head storage cabinet. This has the potential to affect all residents. The ES Director was educated on documentation, safety of fire sprinkler systems, and storage by the administrator. The ES Director/designee will perform sprinkler head storage audits daily X 1 week then weekly X 3 then monthly X 2. Results will be brought to the monthly quality meeting for further recommendations. Date of completion: 6/4/21	

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K 353	Continued From page 4 sprinkler head was corroded. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 353		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to maintain the availability of documentation and records of portable fire extinguishers in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 19.3.5.12, 9.7.4.1, and NFPA 10 Standard for Portable Fire Extinguishers, 2010 edition, section 7.3.1.1.1. This deficient practice could affect all 46 residents. Findings Include: On a facility tour between 09:00 AM and 01:00 PM on 04/28/2021, observations, documents review, and staff interview revealed the following: 1) During the documentation review, no evidence was provided to review the annual fire extinguisher inspection and servicing. 2) During a walk-through of the facility, it was observed in the Boiler Room and Basement corridor that there was obstructed access to fire	K 355	All items blocking the fire extinguishers were immediately removed and the ES director. This has the potential to affect all residents and staff. The administrator provided education to the ES director immediately on yearly servicing and accessibility. The ES Director/designee will perform the annual fire extinguisher inspection and servicing. The ES Director/designee will audit fire extinguisher accessibility daily X 1 week then weekly X 3 then monthly X 2. Results will be brought to the monthly quality meeting for further recommendations. Date of completion: 6/4/21	6/4/21

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K 355	Continued From page 5 extinguishers. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 355		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper security and physical accessibility to an electrical panel in a resident accessible corridor in accordance with the Life Safety Code NFPA 101-2012 edition, sections 19.5.1.1 and 9.1.2, Health Care Facilities Code NFPA 99, section 6.3.2.2.1.3., and the National Electrical Code NFPA 70-2011, section 110.26 This deficient practice could affect all 46 residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/28/2021, during the walk-through of the facility, the following was observed:	K 511	All items blocking the electrical panels were removed and all electrical panels were locked. This has the potential to affect all residents. The administrator provided education to the ES Director immediately on locking electrical panels and keeping them unobstructed. The ES Director/designee will perform electrical box inspection daily X 1 week then weekly X 3 then monthly X 2. Results will be brought to the monthly quality meeting for further recommendations. Date of completion: 6/4/21	6/4/21

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K 511	Continued From page 6 1) Unsecured electrical panels were discovered in the following locations: a. Resident corridor-adjacent to Room 116 b. Resident corridor-across from Room 106 c. Resident corridor-adjacent to Room 110 d. In the Resident Dining Room 2) There was obstructed access to the electrical panel in Room 38. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 511		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to inspect and maintain doors in accordance with the Life Safety Code NFPA 101 - 2012, sections 19.7.3.1, 19.7.6,	K 761	All doors were closed and metal wires/door props were removed. All obstructions from the doors were removed and verbal education was	6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 7 4.6.12, and the Standard for Fire Doors and Other Opening Protectives NFPA 80-2010, section 5.2.1 This deficient practice could affect all 46 residents. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 04/28/2021, observations, staff interview, and documentation reviewed revealed the following: 1)There were no detailed records provided to confirm that the facility had completed or contracted annual maintenance, inspection, and testing of individual fire door assemblies. 2) A basement door at the bottom of the stairwell from the Laundry Room, which was labeled as a fire-rated door, was found to be wired in the open position. 3) A Laundry Room door, labeled as a fire-rated door, was found in a propped open position and not allowed to self-close. 4) A Kitchen door on the right side of the Dining Room was found to be obstructed; the door would not be able to close upon release of the magnetic hold-open device. 5) A Kitchen door on the left side of the Dining Room was found in a propped open position and not allowed to self-close. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 761	provided to staff. Carts that were blocking the doorways will no longer be in use. This has the potential to affect all residents. The administrator provided education to the ED Director immediately on proper documentation, closing fire rated doors, and keeping them unobstructed. The ES Director/designee will perform door closure and obstruction inspection daily X 1 week then weekly X 3 then monthly X 2. Results will be brought to the monthly quality meeting for further recommendations. Date of completion: 6/4/21	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		6/4/21

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	245455	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2021**

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GOOD SAMARITAN SOCIETY - JACKSON	**601 WEST JACKSON** **JACKSON, MN 56143**

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K 914	Continued From page 8 locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation to confirm that annual electrical receptacle testing in resident sleeping rooms had been completed in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, sections 6.3.3.2, 6.3.4.1, and 6.3.4.2. This deficient practice could affect all 46 residents. Findings Include: On a facility tour between 09:00 AM and 01:00 PM on 04/28/2021, no records were provided during documentation review to confirm that the facility had completed or contracted annual electrical receptacle testing at resident bed locations.	K 914	The ES Director was educated on documentation and testing of electrical receptacles in resident rooms. This has the potential to affect all residents. Outlet testing was conducted on 6/3/21. The ES Director/designee will not exceed one year of testing each June. Documentation will accurately represent that is was completed. Date of completion: 6/4/21	

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K 914	Continued From page 9 This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 914		
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 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.	K 918		6/4/21

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K 918	Continued From page 10 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 document review and staff interview, the facility failed to maintain proper maintenance records and documentation for the essential electrical system in accordance with the Health Care Facilities Code, NFPA 99, 2012 edition, section 6.4.1.1.17, and the Standard for Emergency and Standby Power Systems NFPA 110, 2010 edition, 8.3.7, 8.3.8, and 8.4.2.3. This deficient practice could affect all 46 residents. Findings include: On a facility tour between 09:00 AM and 01:00 PM on 04/28/2021, during documentation review, no evidence was provided to confirm that weekly inspections of the emergency generator had been completed since 02/24/2021. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 918	The generator was inspected immediately upon arrival of the ES director on 4/29/21 and weekly thereafter. This has the potential to affect all residents. The administrator educated the ES director or proper inspection and documentation of the emergency generator system. The ES director/designee will perform weekly emergency generator inspections and present them to the monthly quality assurance committee. Date of completion: 6/4/21	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		6/4/21

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K 920	Continued From page 11 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to use commercially approved electrical devices and implement them in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, sections 10.2.3 and 10.2.3.6 and the National Electrical Code NFPA 70 - 2011, sections 408.8(1)(2). This deficient practice could affect any residents within the affected room. Findings include: On a facility tour between 09:00 AM and 01:00 PM on 04/28/2021, during a walk-through of the facility, it was observed in the Business Office that an extension cord and a non-commercial power strip were connected together and being used to supply power to multiple appliances. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 920	The appliances plugged into the power strip were immediately removed and plugged into a wall outlet. This has the potential to affect all residents. The administrator immediately provided education to the business office manager on allowable power strips for appliances. The administrator will provide power strip education during June□s monthly manager meeting. The administrator/designee will perform a daily audit X 1 week then weekly audits X 3 to ensure power strips are used correctly. Findings will be brought to the monthly quality assurance committee. Date of completion: 6/4/21	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101	K 923		6/4/21

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K 923	Continued From page 12 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 923		

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K 923	Continued From page 13 Based on observation and staff interview, the facility failed to maintain proper segregation of medical gas cylinders in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, section 11.6.5. This deficient practice could affect all 46 residents. Findings Include: On a facility tour between 09:00 AM and 01:00 PM on 04/28/2021, during a facility walk-through, it was observed that there was storage of full and empty oxygen cylinders in the Med Gas Storage Room without signage to determine the physical segregation of full and empty cylinders. This deficient practice was confirmed by the Facility Administrator at the time of discovery.	K 923	Signage was properly displayed and the director of nursing contacted our distributer and staff about proper storage for full oxygen tanks and empty oxygen tanks. This has the potential to affect all residents. The administrator provided education to the director of nursing and the ES director. The administrator/designee will audit the oxygen storage room daily X 1 week then weekly X 3 then monthly X 2. Results will be brought to the monthly quality meeting for further recommendations. Date of completion: 6/4/21	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 20, 2021

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

Re: State Nursing Home Licensing Orders
Event ID: O4KV11

Dear Administrator:

The above facility was surveyed on April 26, 2021 through April 29, 2021 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	00303	A. BUILDING: _____ B. WING _____	C 04/29/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/26/21 - 4/29/21, a licensing and complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

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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 found to be SUBSTANTIATED H5455017C (MN67002), H5455019C (MN66781), H5450020C (MN63721) however NO licensing orders were issued. The following complaints was found to be UNSUBSTANTIATED: H5455018C (MN55245) 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 text. You must then indicate in the electronic State licensure process, under the heading	2 000		

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2 000	Continued From page 2 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic	2 302		5/28/21

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2 302	Continued From page 3 topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 8 of 8 employees, licensed practical nurse (LPN)-A, registered nurse (RN)-A, nursing assistant (NA)-A, NA-B, NA-C, NA-D and the director of nursing (DON) and social services, received dementia or Alzheimer's training annually. This had the potential to affect all residents who resided in the facility. Findings include: Record review of annual dementia and Alzheimer training for 2020, indicated this training was not completed for any of the staff members who were selected for review. During an interview on 4//27/21, at 3:09 p.m., the education coordinator (EC) indicated none of the staff completed the training last year and the last dates completed was in 2019. The EC indicated that some other Good Samaritan facilities did all staff meetings for their training, but when the previous administrator left, it was likely just forgotten. During interview on 4/29/21, at 9:27 a.m., the DON indicated the central office switched the education software from one system to another last year, and due to some process changes, it wasn't done last year but it should have been completed.	2 302	1 - Alzheimer's training was assigned to these 8 employees to be completed by 5-25-21 2 - Education was assigned to all employees to be completed by 5-28-21 3 - Alzheimer's education will be assigned yearly for all employees 4 - Administrator/CLDS/DON will audit yearly completion of Education and report to QAPI committee for further recommendations	

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2 302	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could enroll all direct care staff in the appropriate courses and notify them of a timeline for completion. The DON or designee could ensure all direct care staff complete the missed courses via an audit, and could develop a regular audit of facility education course completion to be done following new staff orientation and throughout the year as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care for 1 of 1 resident (R2) who was dependent on staff for assistance with grooming and personal hygiene. Findings include: R2's facesheet printed on 4/29/21, indicated diagnoses that included vascular dementia without behavioral disturbances. R2's quarterly Minimum Data Set (MDS)	2 860	Corrected	5/28/21

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2 860	Continued From page 5 assessment dated 1/20/21, indicated R2 had severe cognitive impairment, had adequate hearing and vision, clear speech, usually understood others and was sometimes understood. R2 was dependent upon staff for bed mobility, transfers, walking, dressing, toileting and hygiene. R2's plan of care, printed on 4/29/21, indicated R2 had an activity of daily living (ADL) self-care deficient related to dementia, with functional and cognitive deficiencies. In addition, the care plan indicated R2 needed assistance of one staff for personal hygiene; however refused cares such as shaving, oral care and changing into clean clothes. Furthermore, R2's care plan indicated he had a history of scratching his arms, hands and legs and staff were to keep his fingernails short. During an observation on 4/26/21, at 6:11 p.m., while in bed, R2's fingernails on both hands were noted as being long and some nails were jagged. Fingernails appeared to have dark material under the nails. R2 was not able to unable to answer questions about his nails. During an observation and interview on 4/28/21, at 8:11 a.m., R2 was up in a wheelchair in his room, waiting for breakfast. Fingernails unchanged from 4/26/21, still long, jagged and dirty. When asked if he would like his nails trimmed, R2 stated he liked them long. R2 also stated he can self-propel himself to the dining room, but according to his MDS, required assistance of one. At 8:16 a.m., a nursing assistant (NA) came to R2's room to wheel him to the dining room. Progress notes dated 4/28/21, at 10:56 p.m., indicated R2 "refused bath." No mention of	2 860		

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2 860	Continued From page 6 attempts to clean and/or trim nails. During an interview on Thursday 4/29/21, at 9:47 a.m. NA-D stated R2's bath day was Wednesday evening. When asked if R2 had a bath last evening; NA-D looked in the NA documentation portion of the electronic medical record (EMR) and stated he did have a bath but could not verify if his nails were also cleaned and trimmed. NA-D stated she personally trimmed resident nails after their baths so they were nice and soft. Together looked at R2's nails and NA-D stated "they should have been trimmed, they're long." During an interview on 4/29/21, at 9:50 a.m., licensed practical nurse (LPN)-A stated R2 received bed baths as he was resistive to tub baths. Together looked at R2's nails and LPN-A stated to R2 "you need a good manicure." During an interview on 4/29/21, at 11:13 a.m., the director of nursing (DON) stated R2's nails were to be checked, cleaned and trimmed with every bath ... even a bed bath. DON added, if he refused to have his nails trimmed, staff needed to document this. DON stated NA's were able to trim resident nails, but if the resident refused, she expected them to tell the nurse. Facility policy titled Restorative, Grooming-Rehab/Skilled, dated 6/26/20, indicated: 1. Staff to assist the resident to complete grooming activities, including grooming of nails. 2. The purpose of grooming is to assist the resident to achieve optimum level of independent function with dignity to improve feelings of self-worth. 3. Use positive and reassuring approach. 4. Suggest changes with a gentle, firm	2 860		

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2 860	Continued From page 7 approach when corrections are needed. 5. Policy included step by step nail grooming instructions for staff. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service all staff on performing activities of daily living including finger nail care for residents. The director of nursing or designee could schedule audits to monitor for compliance. The DON or designee could bring results of audits to the quality assurance committee for further follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 930	Corrected	5/28/21

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2 930	Continued From page 8 review the facility failed to provide appropriate gastrostomy tube flushing to prevent complications for 1 of 1 resident (R19) observed during medication administration. Findings include: R19 was admitted to the facility 12/14/18, with diagnoses including: hemiplegia (paralysis of one side of the body), hemiparesis (weakness or the inability to move on one side of the body), malignant neoplasm (abnormal mass) of the brain, gastritis (inflammation of the lining of the stomach), dysphagia (difficulty or discomfort in swallowing), and a gastrostomy tube (G-tube) for nutrition. R19's quarterly minimum data set (MDS) assessment dated 2/24/21, identified R19 with no cognitive impairment, required total assistance with activities of daily living (ADL), and received nutrition via a feeding tube R19's orders dated 9/9/20, indicated flush with 30 cc (cubic centimeter) of sterile water before medications, 5 cc between medications and 30 cc after all medications. Document total number of cc used. On 4/27/21, at 12:30 p.m. licensed practical nurse (LPN)-A entered R19's room with supplies for medication administration. LPN-A donned gloves, then used a syringe with air and a stethoscope to check placement of R19's gastrostomy tube. LPN-A then filled the syringe with 15 cc (cubic centimeters) of water, then flushed R19's tubing with the water. LPN-F failed to follow physician order and only provided R19 with 15 cc of water via syringe into the gastrostomy tube prior administering medications. LPN-A added water to	2 930		

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2 930	Continued From page 9 the first medication cup containing medication and administered the medication by syringe into R19's gastrostomy tube. LPN-A administered two more medications in same manner for R19 while flushing between each medication with 5 cc. LPN-A then filled the syringe with 15 cc of water, then flushed R19's tubing with the water. LPN-A failed to follow physician order and only provided R19 with 15 cc of water via syringe into the gastrostomy tube after all medications were administered. On 4/29/21, at 1:06 p.m. LPN-A confirmed not flushing R19's G-tube with 30 cc of water prior or after administering medications on 4/27/21. LPN-A further confirmed her usual practice was to flush the G-tube with 30 cc of water before and after administering medications as ordered. On 4/28/21, at 2:14 p.m. director of nursing (DON) indicated it would be her expectation for nursing staff to provide consistent care, which should include prior flushing before medications administered, between medications given, and after medication administration as ordered by the physician. The DON indicated she would expect nursing staff to follow R19's physician orders. The facility policy titled Medication: Tube Administration-Rehab/Skilled dated 2/10/21 indicated: - Purified or sterile water is recommended for all preparation and administration of medication due to the risk of undesired molecular combinations that could occur with crushed medications and impure water. Policy/Procedure 1. Verify physician's order. 6. Flush tube with 30 (cc) of purified or sterile water before and after administering each	2 930		

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2 930	Continued From page 10 medication pass. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train and educate staff related to care of gastrostomy tubes and complete audits to ensure monitoring and compliance. The DON or designee could bring results of audits to the quality assurance committee for further follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a manner that was palatable to the residents. This deficient practice had the potential to affect all 39 residents residing in the facility who consumed food from the kitchen. Finding include: During an interview on 4/26/21, at 2:37 p.m., R12 stated the food was very bad, adding that her family brought her a refrigerator for her room so she could keep her own food to eat. R12 stated she had told "anybody who will listen [about the food] -- it's no secrete." R12 stated the dietary	2 960	Corrected	5/28/21

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2 960	Continued From page 11	2 960		

department was short staffed and the staff kept turning over. R12 stated the mixed vegetables were mush and cinnamon rolls on 4/25/21 were burnt on the bottom -- dry and hard -- and she could not eat the bottom of the roll.

During an interview on 4/26/21, at 3:07 p.m., R7 stated the food was so bad, he got his own refrigerator and his daughter brought food in for him. R7 stated the quality of food is bad and the cooking is bad, adding he had told staff how bad it was, but nothing ever got done about it.

During an interview on 4/26/21, at 6:30 p.m., R12 stated she wanted small portions, but didn't get them, even though she had told the kitchen staff. R12 stated the food is often overdone, giving an example of overdone hamburgers that were served which were hard around the edges. At the same meal, she received a cookie that was so overdone, she couldn't bite into it. R12 stated one of the staff said to her that day: "I think we're having an overdone meal tonight."

During an observation in the dining room on 4/28/21, at 8:47 a.m., observed R2 and R29 had what appeared to be bacon on their plates, but it was in pieces and was dark and dry looking; it appeared overcooked. Asked certified dietary manager (CDM)-C who was in the dining room, to look at the bacon and she stated "that's overcooked; it should look pretty for the residents." In the kitchen, cook (C)-A was asked about the bacon being dark and dry. C-A stated "that's the way it comes - precooked." C-A stated the bacon was a new product. Looking at the bacon on the steam table, C-A stated "I didn't realize it was as done as it was." C-A obtained the box of bacon from the refrigerator which read: "Hormel Fast 'n Easy Bacon - Fully Cooked

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2 960	Continued From page 12	2 960		

Rounds." Heating instructions for a conventional oven indicated to preheat to 400 degrees Fahrenheit and heat for approximately three minutes to desired crispness. C-A stated she didn't read the instructions and cooked it at 350 degrees for 15 minutes, adding "I saw it was dark, but I didn't think anything of it." Looking at bacon rounds in the steam table, C-A admitted the bacon was dry, dark and hard and should not have been served to residents. Resident R29 ate everything on his plate except the bacon, stating it was "too hard to chew."

During an interview on 4/28/21, at 9:10 a.m., R12 who was in her room, eating breakfast, stated "I don't like big portions and I've told them. I don't want their bread because I don't like the butter substitute they use; I've told them, but I still get it." Toast was observed on her plate. Stated she told this to CDM-B. "Not only is the food terrible, but it's such a waste if we can't eat it." "We look forward to the food - what else do we have to look forward to?" Observed R12's meal card on her breakfast tray; and there was nothing on it about portion sizes or her likes/dislikes.

During an observation on 4/28/21, at 11:15 a.m., C-A removed two approximately 10 inch by 12 inch foil pans of lasagna from the oven which had areas of burnt cheese on top. C-A stated "it always looks like that." The burnt cheese extended two to three inches into the center of the lasagna. CDM-C looked at it and instructed C-A to removed the burnt areas. C-A scraped it off with a rubber spatula, then added shredded mozzarella cheese over top. At 11:57 a.m., C-A removed a third pan of lasagna from the oven. This pan of lasagna had a greater area of burnt cheese than the first two pans. The burnt cheese was scraped off by C-A, effectively removing the

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2 960	Continued From page 13 top layer of the lasagna, and added shredded mozzarella cheese. C-A stated she would not have served the burnt lasagna to residents; she would have cut around the burnt areas. During an interview on 4/28/21, at 1:38 pm., the administrator stated CDM-B who was at the facility on 4/26/21, was no longer with the facility; she had resigned and there was a corporate CDM-C at the facility until a new CDM could be hired. Administrator was unaware of food quality concerns by residents and was informed of resident complaints about food being overcooked, and observations of overcooked bacon and burnt cheese on lasagna. The administrator stated it had been a challenge as they had been working short in the kitchen and the CDM had to work as the cook, so some things hadn't been kept up. During document review on 4/28/21, at 3:10 pm., reviewed C-A's qualifications to work as a cook. C-A had a ServSafe Certification obtained on 10/24/18, expiring on 10/24/23. According to the administrator, C-A had a performance improvement plan in September 2019, related to quantity and portion control and sanitary environment. This was extended on 10/23/19 due to additional complaints. The administrator reiterated they were short staffed in the kitchen and there was lack of oversight of cooks because the dietary manager had to work as a cook. The administrator stated CDM-C would be at the facility until a new CDM was hired. Facility policy titled Dining Service Standards - Food and Nutrition Services, dated 4/5/21, indicated: 1. Residents will be provided meals that are nourishing, attractive, and palatable and served at	2 960		

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2 960	Continued From page 14 a safe and appetizing temperature. 2. Take into consideration each resident's individual needs and food preference. 3. Meals will be based on available resident information (e.g., resident choice/preferences, tray/diet cards). SUGGESTED METHOD FOR CORRECTION: The director of dietary or designee could review and revise policies and procedures to ensure compliance for nutritive and palatable food. A dining committee could be developed for residents. The director of dietary or designee could conduct audits and bring results of audits to the quality assurance committee for further follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 960		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for periodic reconciliation of controlled or narcotic medications in 1 of 1 emergency kit (E-Kit) and 3 of 3 refrigerators to prevent potential loss or diversion. This had the potential to affect any of the 39 residents present in the facility who may require controlled medications from the E-Kit and	21550	Corrected	5/28/21

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21550	Continued From page 15 refrigerators. Findings include: On 4/26/21, at 6:40 p.m. a tour of the north unit medication room was conducted with licensed practical nurse (LPN)-B. Located within the medication room was a locked cabinet with an E-Kit. The E-kit was observed to have an unsecured green tag present and included lorazepam (an anti-anxiety medication/controlled substance), morphine (narcotic pain medication/controlled substance), diazepam (an anti-anxiety medication/controlled substance), and hydrocodone (a narcotic pain medication/controlled substance). LPN-B indicated if the E-Kit was opened and medications were removed, nursing staff would remove the red tag (which locked the E-Kit) and replaced with a green tag to secure the E-Kit until the pharmacy came to change out the E-Kit. LPN-B was unsure how often pharmacy came to the facility. LPN-B confirmed being aware the E-kit included lorazepam, hydrocodone, morphine, diazepam and further confirmed nursing staff did not include the narcotic contents from the E-Kit with their narcotic counts. LPN-B stated when medications were removed from the E-kit, pharmacy was notified and would bring a new E-kit to replace the opened one. LPN-B confirmed three of the hydrocodone were removed from the E-kit last week and were signed out by LPN-B and another nurse and further confirmed the contents of the E-kit had not been reconciled since. The tour further indicated two medication refrigerators on north unit to contain a 2 mg lorazepam vials located in each refrigerator and LPN-B confirmed the lorazepam was not being reconciled.	21550		

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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
21550	Continued From page 16 On 4/26/21, at 7:02 p.m. the director of nursing (DON) confirmed the E-kit should be restocked by pharmacy the next day when medications are removed. The DON further confirmed the E-Kit should be locked and reconciled daily. On 4/28/21, at 12:00 p.m. the south medication room refrigerator was observed with licensed registered nurse (RN)-A and included a vial of lorazepam. RN-A could not find documentation the lorazepam was reconciled daily, though stated previously nursing staff had been reconciling. The policy titled, Medications: Controlled Medication Storage, dated 12/11/2020, included: 3. Each time the keys that secure controlled medications change from one nurse/medication aide to another, the oncoming an off-going nurse/medication aide will work together to reconcile all controlled medications, including all discontinued controlled medications and document the same. 4. The access system used to lock controlled medications cannot be the same access system used to lock non-controlled medications. 5. Controlled medications needing refrigeration will be double locked in a permanently affixed compartment within the medication refrigerator. For all schedule II-controlled medications -1. The nurse going off shift unlocks a controlled medication storage unit(s) and will then go to the narcotic count book and read each GSS # 247 page to the on-coming nurse. The on-coming nurse will verify that the physical medication count matches the remaining amount listed in the GSS#247 for each medication. Controlled medications that have been discontinued should be placed in a lock box in the medication room as soon as they have been discontinued, or as	21550		

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21550	Continued From page 17 indicated by state regulation. Controlled medications should continue to be counted by two nurses until disposal is completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and the consulting pharmacist could establish a system for accurate accounting of medications in the emergency kits to prevent potential loss or diversion. The DON could randomly audit the system and report audits to the quality assurance committee for further follow up to ensure ongoing compliance. TIME PERIOD OF CORRECTION: Twenty-One (21) days.	21550		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe medication refrigerator temperatures were maintained in 2 of 2 nursing units (north and south) to ensure medication efficacy. This had the potential to affect all 39 residents. Findings include: On 4/26/21, at 7:02 p.m. during observation of the north unit medication room with licensed practical	21610	Corrected	5/28/21

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21610	Continued From page 18 nurse (LPN)-B the medication refrigerator temperature log was reviewed and revealed the medication refrigerator was to be maintained between 36-46 degrees Fahrenheit (F). LPN-B confirmed there were temperatures out of range and no action was taken for the out-of-range temperatures. The medications in the south medication fridge included lorazepam 2 milligram (mg) vial, Novolog vial (insulin), insulin pen, and tuberculin. The April 2021 log for the north medication indicated the following temperatures were not within range: 4/3/21, 30 degrees F. 4/7/21, 30 degrees F. 4/17/21, 30 degrees F. 4/19/21, 28 degrees F. 4/20/21, 30 degrees F. 4/22/21, 34 degrees F. 4/24/21,32 degrees F. Interview on 4/28/21, at 9:07 a.m. with the director of nursing (DON) confirmed she received the refrigerator readings each month to review. The DON confirmed she reviewed March 2021 logs for the north and south medication refrigerators and verified there were temperatures out of range. The DON further confirmed she did not act on the out-of-range temperatures. The DON stated she would expect the nursing staff to notify her when the medication refrigerator temperatures were out of range and she would notify maintenance. The DON confirmed she should have acted on the out-of-range temperatures when she reviewed the temperature logs at the end of the month. On 4/28/21, at 10:00 a.m. observed the south unit medication room with registered nurse (RN)-A; the refrigerator temperature documentation was	21610		

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21610	Continued From page 19 posted on the front the of refrigerator for April 2021. The refrigerator medications included pantoprazole liquid suspension, acetaminophen suppositories, insulin 70/30, insulin pen, and lorazepam vial. RN-A stated when she noted the temperature to be at 32 degrees or below, she would adjust the fridge's temperature dial. The April 2021 log for the south medication indicated the following temperatures were not within range: 4/2/21, 30.8 degrees F 4/3/21. 32.9 degrees F 4/85/21, 29.7 degrees F 4/7/21, 29 degrees F 4/9/21, 28.1 degrees F 4/13/21, 25.4 degrees F 4/14/21, 24.8 degrees F 4/15/21, 20.9 degrees F and 33.0 degrees F 4/16/21, 20.9 degrees F and 26.5 degrees F 4/18/21, 21.2 degrees F 4/19/21, 25.6 F degrees and 22.9 degrees F 4/20/21, 26.8 degrees F 4/22/21, 24.1 degrees F 4/24/21, 23.6 degrees F 4/27/21, 23.2 degrees F 4/28/21 28.4 degrees F Interview on 4/28/2, at 10:56 a.m. interview with the consulting pharmacist stated the medication refrigerators should remain between 36-46 degrees. The pharmacist indicated temperatures below 36 degrees break down the insulin, and the temperature of the insulin should remain between 36-46 degrees. The pharmacist confirmed if the refrigerator temperatures were not within range the insulin and other medications should not be used. The pharmacist further confirmed the insulin and other medications would not be as	21610		

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21610	Continued From page 20	21610		

effective for the residents. The pharmacist verified she reviewed resident's medications monthly and went into the facility quarterly. The pharmacist confirmed there had been no residents with frequent insulin adjustments. The pharmacist verified last being in the facility at the end of January 2021 and had not observed concerns with the medication refrigerator temperatures at that time.

On 4/28/21, 12:00 p.m. the south medication refrigerator was observed with the DON. The inside back of the refrigerator was observed with ice buildup. Medications in the refrigerator included pantoprazole liquid, acetaminophen suppositories, insulin 70/30, and lorazepam. The DON confirmed the bag the lorazepam vial was in contained water and condensation and could indicate the lorazepam could have previously been frozen. The insulin vial was observed with a formed particle in the vial and small formed particles floating in liquid. The DON confirmed the documented temperatures and verified 32 degrees or below was freezing.

On 4/28/21, at 2:14 p.m. the DON stated she verified the temperature of the south refrigerator with another thermometer. The DON stated both thermometers read 37 degrees and confirmed the thermometer was reading temperatures correctly. The DON stated the pantoprazole was the only medication opened and used for R19. The pantoprazole was dispensed 4/21/21 and the other medications were not opened or used.

On 4/29/21, 9:48 a.m. maintenance supervisor (MS)-A stated he was not aware of any issues with the refrigerators and staff had not discussed any issues with the temperatures of the refrigerators. MS-A confirmed a maintenance

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21610	Continued From page 21 book was located in the nursing station for staff to utilize and record maintenance concerns. The book was observed to have no concerns related to the refrigerators. MS-A further confirmed staff would also put a note on his door related to equipment concerns and he had not received any notes from staff related to the refrigerator. On 4/28/21, at 1:30 p.m. LPN-C stated the night nurses and evening nurses were responsible to record refrigerator temperatures and verified the staff did not follow through with the expectations of reporting temperatures below 36 degrees in the medication refrigerators. The package inserts for the Humulin 70/30: -store not in-use (unopened) HUMULIN 70/30 vials refrigerated. -store in a refrigerator (36° to 46°F [2° to 8°C]), but not in the freezer. -do not use if it has been frozen. - if stored at room temperature, below 86°F (30°C) the vial must be discarded after 31 days. Storage for Protonix for delayed-release oral suspension included: - 20° to 25°C (68° to 77°F); excursions permitted to 15° to 30°C (59° to 86°F). - Do not freeze. The document titled maintenance request sheet for the months of January 2021-April 2021 did not contain any concerns regarding the refrigerators. The document titled Medications: Acquisition Receiving Dispensing and Storage-Rehab/Skilled dated 12/28/20, indicated: - All medications will be stored in accordance with manufacturers' recommendations. - Refrigerators holding medications (such as	21610		

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21610	Continued From page 22 insulin, etc.) will be kept between 36 degrees F and 46 degrees F. Medications rooms will be kept between 59-degree F and 29-degree F. Check refrigerator temperatures daily.. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff on importance of temperature control for insulin, immunizations and other medications requiring refrigeration according to manufacturer instructions. The DON or designee could audit the temperatures have been checked, documented and any temperatures outside the posted safe zone have been appropriately responded to. The DON or designee could bring results of audits to the quality assurance committee for further follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
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, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe and sanitary environment for residents as a result of peeling ceiling paint in the kitchen over a food preparation surface. This	21695	Corrected	5/28/21

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21695	Continued From page 23	21695		

had the potential to affect all 39 residents residing in the facility who consumed food from the kitchen.

Findings include:

During an observation on 4/28/21, at 11:05 a.m., peeling paint was noted on two areas of the kitchen ceiling. The ceiling was a solid, flat surface, painted a white/cream color. Directly over a metal food preparation surface was an area of peeling paint, including a flap of paint about the size of a hand, hanging down over the work surface. On the metal work surface was a jar of peanut butter and a knife. In addition, there was a circular area of peeling ceiling paint near the exit of the kitchen going into the dining room. This area was approximately 18-24 inches in diameter, with peeling paint around the perimeter of the circle. While this area of peeling paint was not directly above a food preparation surface, food was removed from the microwave and carried underneath it. Carts containing resident trays passed under this area also.

During an interview on 4/28/21, at 11:08 a.m., cook (C)-A was asked if she was aware of the peeling paint on the ceiling, and stated, "yeah, I seen that" and "maintenance supervisor (MS)-A knows about it." C-A was not able to say how long it had been there, and had not seen paint chips fall onto the food preparation surface.

During an interview on 4/29/21, at 11:45 a.m., the administrator was unaware of the peeling paint on the kitchen ceiling and would work with MS-A to correct the problem right away.

During a telephone interview on 4/29/21, at 11:57 a.m., MS-A stated he was aware of the peeling

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21695	Continued From page 24 paint on the ceiling in the kitchen. MS-A stated there were problems with the roof and when it rained, the paint on the ceiling in the kitchen peeled. MS-A stated he had not been able to work on it due to other priorities. He is the only maintenance worker and finds it challenging to maintain the building on his own, however would work on it in the next couple of weeks. MS-A acknowledged that paint dropping into resident food or food preparation surfaces was a safety and infection control concern. Facility policy titled Cleaning Schedule - Food and Nutrition Services, dated 3/31/21, indicated: 1. Ceilings: check for cobwebs, dust and dirt or condensation so it cannot fall from the ceiling. 2. Ceilings were to be spot-cleaned on an as needed basis. SUGGESTED METHOD OF CORRECTION: The administrator or designee could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure building maintenance and painting is adequately completed. The administrator or designee 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		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize,	21915		5/28/21

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21915	Continued From page 25 maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 39 resident families who reside in the facility. Findings include: During interview on 4/28/21, at 10:30 a.m., the social services designee (SSD) confirmed the facility did not have an existing family council nor has a letter been sent to families related to interest in forming a family council since November of 2019 prior to her assuming the SSD position. During interview on 4/29/21, at 9:27 a.m. the director of nursing indicated she was aware no attempts were made over the past year to form a family council, and confirms it should have been done. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure attempts are made to develop a family council. The administrator or her designee could develop monitoring systems to ensure attempts are made	21915	1 - Family Council was scheduled for June 7, 2021 at 7pm 2 - Family Council will be scheduled twice every calendar. 3 - Administrator/Social Service will schedule the Family council twice a year 4 - Social Service/Administrator will audit every 6 months X 1 year will results to QAPI committee for further recommendations.	

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21915	Continued From page 26 to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure attempts are made to develop a family council. The administrator or her designee could develop monitoring systems to ensure attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915		