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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PELM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245558**

2.STATE VENDOR OR MEDICAID NO.
(L2) **677840200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

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 **10/28/2021** (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 **72** (L18)
13.Total Certified Beds **72** (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
	72			
(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 11/30/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/30/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
05/01/1991
(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
11/01/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 30, 2021

CMS Certification Number (CCN): 245558

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

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 October 11, 2021 the above facility is certified for:

72 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 72 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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 30, 2021

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: CCN: 245558
Cycle Start Date: August 26, 2021

Dear Administrator:

On September 21, 2021, we notified you a remedy was imposed. On October 28, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 11, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 5, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 21, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 5, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 11, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PELM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

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2.STATE VENDOR OR MEDICAID NO.
(L2) **677840200**

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(L3) **GOOD SAMARITAN SOCIETY - WINDOM**
(L4) **705 SIXTH STREET**
(L5) **WINDOM, MN** (L6) **56101**

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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 **08/26/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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

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To (b) :

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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
	72			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Alisha Jordan, HFE NE II 10/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/29/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1991
(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
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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

Electronically delivered
September 21, 2021

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: CCN: 245558
Cycle Start Date: August 26, 2021

Dear Administrator:

On August 26, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 5, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 5, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 5, 2021.

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

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 5, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Windom will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 5, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" 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, Minnesota 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 26, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET** **WINDOM, MN 56101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/26/2021. At the time of this survey, GOOD SAMARITAN SOCIETY - WINDOM 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 | 10/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET** **WINDOM, MN 56101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 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 - WINDOM was constructed at five different times. A one-story building with a partial basement was constructed in 1959 and determined to be Type II (111). Additions were added in 1962, 1972, 1994, 2000, and all were determined to be Type II (111). Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET** **WINDOM, MN 56101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 72 beds and had a census of 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit discharges in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2, 7.1.7, 7.7. These deficient conditions could have a widespread impact on the residents within the facility. Findings include:	K 271	K-271 Corrected Date: Sept. 30, 2021 The exits for the Southwest door, 2 Northeast Dining Room doors, Northwest door, and Southeast door were repaired on Sept. 23, 2021 by the Maintenance Director to assure a smooth exit path. Annual Door inspections, which include	9/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET** **WINDOM, MN 56101**

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K 271	Continued From page 3 On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that the following exit discharge sidewalks had vertical displacement greater than one-half inch. 1. Southwest Exit 2. Both Dining Room exits 3. Northwest Exit 4. Southeast Exit These deficient conditions were confirmed by the Facility Maintenance Director at the time of discovery.	K 271	inspecting the exit discharge sidewalks, were re-implemented on Sept. 1, 2021. All other door exits were reviewed and found compliant. Maintenance employees were educated by the Maintenance Director and Administrator on Sept. 30, 2021, regarding door and exit inspections. The annual door inspections have been added to the TELS preventative maintenance system, which produces a weekly report of tasks not completed. The 2021 annual door inspections that were completed on Sept. 1, 2021, were reviewed at the Sept. 29, 2021 Safety Committee meeting for compliance. This issue was reported to the QAPI Committee on Sept. 29, 2021, for follow-up.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation staff interview, the facility failed to maintain access to the manual fire alarm system devices in accordance with NFPA 101	K 345	K-345 Corrected Date: Oct. 8, 2021	10/8/21

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	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2021**

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K 345	Continued From page 4 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.1.4, 19.3.4.2.2(1), and NFPA 72 (2010 edition), National Fire Alarm and Signal Code, sections 10.16.3.1, 10.16.4, 17.14.5. These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 08/26/2021, between 11:00, AM to 04:00 PM, it was revealed during the walk-through of the facility that the manual pull stations located adjacent to RM 512 and adjacent to the NW exit were obstructed. 2. On 08/26/2021, between 11:00 AM to 04:00 PM, it was revealed during the walk-through of the facility that the fire alarm annunciator panel at the front entrance was physically and visually obstructed. These deficient conditions were confirmed by the Facility Maintenance Director.	K 345	During the walk-thru on Aug. 26, 2021, the 2 pull stations and annunciator panel observed to be not clear to the floor were immediately remedied. All pull stations and annunciator panels were observed and no others were found to be obstructed. Maintenance employees were educated by the Maintenance Director and Administrator on Sept. 30, 2021, regarding the importance of assuring pull stations and annunciator panels are clear of obstructions. All employees were re-educated on the topic on Oct. 4-8, 2021, through learning boards and a post-quiz developed by the Administrator, Director of Nursing, and a Case Manager. Audits of pull stations and annunciator panels for clearance of obstructions will occur by the QAPI Coordinator or designee 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks, and then monthly times 2 months. This issue was reported to the Safety and QAPI Committees on Sept. 29, 2021, for follow-up. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	
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	K 353		10/8/21

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K 353	Continued From page 5 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5 and 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2, 5.2.1.1.1, 5.2.1.1.2, 5.2.1.1.4, 5.2.1.2, and NFPA13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, 8.5.6.1. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: 1. On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that sprinkler heads in the following locations were obstructed by storage and items within 18 inches of the sprinkler deflector:	K 353	K-353 Corrected Date: Oct. 8, 2021 The sprinkler head obstructions in the PT storage closet, rooms 408, 219, 200G, and the corridor closet adjacent to room 403, were corrected on Aug. 26, 2021. The sprinkler heads with oxidation and paint were replaced by Building Sprinkler Inc. on Sept. 28, 2021. All additional sprinkler heads were audited for obstructions, oxidation, and paint by the Maintenance Director on Sept. 27, 2021. Any needed storage corrections were made immediately. Three additional potential oxidation issues were identified and replace on Sept. 28, 2021. Tape/signs, to indicate storage height limits, were placed by maintenance	

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K 353	Continued From page 6 a. Physical Therapy storage closet b. Room 408 c. Corridor closet adjacent to Room 403 d. Room 219 e. Room 200G 2. On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-through of the facility that sprinkler heads in the following locations exhibited signs of oxidation: a. Kitchen Dish-washing Area b. Room 302 c. Room 200G 3. On 08/26/ 2021, between 11:00 AM to 04:00 PM, it was revealed during the walk-through of the facility that the sprinkler head in Room 500D was covered with paint. These deficient conditions were confirmed by the Facility Maintenance Director.	K 353	employees in all storage spaces to assist all employees, clients, and families in understanding the distance requirements, Sept. 27-30, 2021. Maintenance employees were educated by the Maintenance Director and Administrator on Sept. 30, 2021, regarding sprinkler head storage limits as well as sprinkler head condition requirements. They are to correct the issue immediately, if possible, and then report issues to the maintenance hotline for further follow-up. All employees were educated Oct. 4-8, 2021, regarding storage spaces and sprinkler head clearance requirements. All clients and families were educated on Oct. 1, 2021, via email/mail and in person on Oct. 6, 2021, at the resident council meeting by the Administrator and Maintenance Director, regarding storage spaces and sprinkler head clearance requirements. Sprinkler head inspections have been added to the TELS preventative maintenance system. October, 2021-March 2022, the monthly sprinkler head inspections will be reviewed at the monthly Safety Committee meeting for compliance with completion and correction if needed. Audits of storage spaces in relation to sprinkler head clearance will occur by the QAPI Coordinator or designee 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks, and then monthly times 2	

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K 353	Continued From page 7	K 353	months. This issue was reported to the Safety and QAPI Committees on Sept. 29, 2021 for follow-up. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the smoke barrier doors to resist the passage of smoke per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3 and 8.5.4.1. This deficient condition could have an isolated impact on the residents within the facility. Findings include:	K 374	K-374 Corrected Date: Sept. 30, 2021 The dining room smoke barrier doors were fixed immediately during the Aug. 26, 2021 inspection. All other smoke barrier doors were found to be in compliance on Aug. 26, 2021. Maintenance employees were educated	9/30/21

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K 374	Continued From page 8 On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-thru of the facility that the Dining Room smoke barrier doors, when tested, did not close properly. This deficient condition was verified by the Maintenance Director.	K 374	by the Maintenance Director and Administrator on Sept. 30, 2021, regarding smoke barrier doors and inspections. The annual door inspections have been added to the TELS preventative maintenance system, which produces a weekly report of tasks not completed. The 2021 annual door inspections that were completed on Sept. 1, 2021, were reviewed at the Sept. 29, 2021 Safety Committee meeting for compliance. This issue was reported to the QAPI Committee on Sept. 29, 2021 for follow-up. This issue was reported to the QAPI Committee on Sept. 29, 2021, for follow-up. K-511 Corrected Date: Sept. 30, 2021 Locks were added to the electric panels on the 400 wing, Southwest corridor, and west corridor by the Maintenance Director on Sept. 10, 2021. All other panels had locks when inspected on Aug. 26, 2021. Maintenance employees were educated by the Maintenance Director and Administrator on Sept. 30, 2021, regarding electric panel locking requirements. This issue was reported to the Safety and QAPI Committees on Sept. 29, 2021, for follow-up.	

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K 511	Continued From page 9	K 511		
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 security to electrical panels in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26, and NFPA 99, (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient conditions could have a widespread impact on the residents within the facility. Findings include: On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-thru of the facility that the following electrical panels in resident accessible corridors were unsecured: 1. 400 Wing 2. Southwest corridor 3. West corridor	K 511	K-511 Corrected Date: Sept. 30, 2021 Locks were added to the electric panels on the 400 wing, Southwest corridor, and west corridor by the Maintenance Director on Sept. 10, 2021. All other panels had locks when inspected on Aug. 26, 2021. Maintenance employees were educated by the Maintenance Director and Administrator on Sept. 30, 2021, regarding electric panel locking requirements. This issue was reported to the Safety and QAPI Committees on Sept. 29, 2021, for follow-up.	9/30/21

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K 511	Continued From page 10 These deficient conditions were confirmed by the Maintenance Director.	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, review of available documentation, and staff interview, the facility failed to inspect and maintain door assemblies per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.3.1, 19.7.6, 4.6.12, 7.2.1.7, 7.2.1.4.5.1 and NFPA 80 (2010 edition), sections 5.2.1, 6.1, 6.1.4.2 This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed that upon testing the Dining Room exit door, it required greater than 30 pounds of force to open the door.	K 761	K-761 Corrected Date: Sept. 30, 2021 The dining room door exit was fixed on Sept. 15, 2021, by the Maintenance Director. All other doors were inspected for the same issue on Aug. 26, 2021 and were found to be in compliance. Annual door inspections were started on Sept. 1, 2021, by the Maintenance Director. Maintenance employees were educated by the Maintenance Director and Administrator on Sept. 30, 2021, regarding annual door inspections and	9/30/21

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	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2021**

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K 761	Continued From page 11 2. On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed during documentation review that no documentation was presented to confirm that annual fire door inspections had occurred since 2017. This deficient condition was verified by the Maintenance Director.	K 761	how to follow-up. The annual door inspections have been added to the TELS preventative maintenance system, which produces a weekly report of tasks not completed. The 2021 annual door inspections that were completed on Sept. 1, 2021, were reviewed at the Sept. 29, 2021 Safety Committee meeting for compliance. This issue was reported to the QAPI Committee on Sept. 29, 2021, for follow-up.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	K 914		9/30/21

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	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2021**

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K 914	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to complete receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed during documentation review that no documentation was presented to confirm that electrical outlet testing of the resident rooms had occurred since 2016. This deficient condition was verified by the Maintenance Director.	K 914	K-914 Corrected Date: Sept. 30, 2021 Annual testing was initiated on Sept. 1, 2021 by the Maintenance Director. All electric receptacles were tested in resident rooms Sept. 21-25, 2021 by the Maintenance Director. Any corrections were completed and verified immediately. Maintenance employees were educated by the Maintenance Director and Administrator on Sept. 30, 2021, regarding annual electric receptacle inspections and how to follow-up. The annual electric receptacle inspections have been added to the TELS preventative maintenance system, which produces a weekly report of tasks not completed. The 2021 annual electric receptacle inspections that were completed Sept. 21-25, 2021, were reviewed at the Sept. 29, 2021 Safety Committee meeting for compliance. This issue was reported to the QAPI Committee on Sept. 29, 2021, for follow-up.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment	K 920		10/8/21

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K 920	Continued From page 13 (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly implement the usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). These deficient conditions could have a patterned impact on the residents within the facility. Findings include: 1. On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed during facility walk-thru of the facility that multi-tap electrical adapters were in use in the Training Room. 2. On 08/26/2021 between 11:00 AM to 4:00 PM,	K 920	K-920 Corrected Date: Oct. 8, 2021 The multi-tap adapter in the training room was replaced on Sept. 8, 2021, by the Maintenance Director. The room 107A extension cord that was connected to a power strip was removed on Aug. 26, 2021 by the Maintenance Director. All rooms were inspected on Sept. 21, 2021 for extension cords and multi-tap cords with any extension cords or multi-tap issues corrected immediately. Maintenance employees were educated on Sept. 30, 2021, by the Maintenance Director and Administrator regarding use of extension cords/multi-taps. They are to	

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	245558	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/26/2021**

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GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET** **WINDOM, MN 56101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 14 it was revealed during facility walk-thru of the facility that an extension cord connected to a power strip was in use in Room 107A. These deficient conditions were confirmed by the Maintenance Director.	K 920	correct the issue immediately, if possible, and then report issues to the maintenance hotline for further follow-up. All employees were educated Oct. 4-8, 2021, regarding use of extension cords/multi-taps, through learning boards and a post-quiz developed by the Administrator, Director of Nursing, and a Case Manager All clients and families will be educated on Oct. 1, 2021, via email/mail and in person on Oct. 6, 2021, at the resident council meeting by the Administrator and Maintenance Director regarding the use of extension cords/multi-taps. This information has been added to the admission packets as well. Quarterly audits of all spaces for extension cords/multi-taps has been added to the TELS preventative maintenance system. Audits for the presence of extension cords or multi-tap cords will occur by the QAPI Coordinator or designee 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks, and then monthly times 2 months. This issue was reported to the Safety and QAPI Committees on Sept. 29, 2021, for follow-up. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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E 000	Initial Comments On 8/23/21-8/26/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/23/21-8/26/21, 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 complaint were found to be UNSUBSTANTIATED: H5558028C (MN00051263), H5558027C (MN00058952) 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 substantial compliance with the regulations has been attained.	F 000		
F 550	Resident Rights/Exercise of Rights	F 550		10/8/21

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

Electronically Signed | 10/01/2021

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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F 550 SS=D	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550		

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F 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 1 resident (R29) who were required assistance with activities of daily living (ADLs). Findings include: R29's facesheet printed 8/25/21, indicated R29 was admitted to the facility 1/4/21, and diagnoses included glaucoma, abnormalities of gait and mobility, and pain in left hip. R29's quarterly Minimum Data Set (MDS) assessment dated 7/9/21, identified R29 was cognitively intact and required two person physical assist with dressing, toilet use, personal hygiene, bathing, and utilized a wheelchair for mobility. R29's care plan dated 1/4/21, indicated an ADL self care performance deficit R/T [related to] weakness and inability to independently dress, groom, toilet and bathe self and interventions included dressing with total assist of 1-2 with lower body, encourage participation with upper; toilet use total lift, large sling and 2 assist to transfer on/off commode/toilet and total assist with clothing management and hygiene. On 8/23/21, at 3:40 p.m. R29 was observed and interviewed while seated in a wheelchair in his room. R29's pants were observed poor fitting, baggy, with snaps at each side not buttoned, or	F 550	F-550 Correction Order #21805 Corrected Date: October 8, 2021 It is the current policy and procedure of GSS-Windom to provide care consistent with resident dignity. R29: The pants were changed and removed on Aug. 25, 2021. Available employees were re-educated immediately. All residents are at risk for this deficient practice. An audit was conducted by a Case Manager on Oct. 1, 2021 of resident clothing and any additional clothing that did not fit properly was removed. To prevent further potential deficient practice, all nursing staff were re-educated Oct. 4-8, 2021, through learning boards and a post-quiz developed by the Administrator, Director of Nursing, and a Case Manager regarding the resident□s right to dignity, especially in regard to proper fitting clothing. At the Oct. 6 resident council meeting, the administrator will review the right to dignity with the residents. A random audit of residents regarding proper fitting clothing will be conducted by the QAPI Coordinator or designee, 3 times weekly for 4 weeks and then 1 time	

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F 550	Continued From page 3 pulled up around R29's waist. R29 stated "my pants are embarrassing" and further indicated he went to breakfast, noon meal, and bingo dressed as he was. R29 stated could fit "two elephants" in his pants . R29 indicated he wanted to get rid of the pants he had on, and stated he didn't get to choose his pants, and stated he would never want to wear these [pants]. R29 further indicated he "dreads" when staff take out the pants. On 8/263/21, at 3:46 p.m. licensed practical nurse (LPN)-A stated R29 had adaptive pants, and confirmed the pants were extremely large for the resident and should be buttoned at the sides of the waist. LPN further stated he had other adaptive pants that fit appropriately to wear. On 8/25/21, at 7:37 a.m. nursing assistant (NA)-A stated R29's adaptive pants were too big and were exchanged for smaller pants. On 8/25/21, at 7:41 a.m. the director nursed (DON) stated when residents utilized a lift (mechanical devise used to assist with transfer) adaptive pants were used and social services arranged with the family the correct size and style. The DON stated R29 should not have been dressed with extremely baggy pants and expected the pants to be fastened. On 8/25/21, at 7:42 a.m. an interview with registered nurse (RN)-J stated the pants R29 wore on 8/23/21 were his personal adaptive pants. RN-J confirmed the pants were too large and were given to social services to take out the residents clothing choices. RN-J stated staff were expected to dress residents with well fitted clothing and appearance was important to R29.	F 550	per week for 8 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 550	Continued From page 4 Policy titled Activities of Daily living rehab/skilled dated 12/28/28, indicated -Purpose: To provide residents with appropriate treatment and services to maintain or improve abilities in activities of daily living for the well being of mind, body and soul. - Policy any resident who is unable to carry out activities of daily living or receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. - Dressing: selecting, obtaining and putting on, fastening and taking off items of clothing including braces and prosthesis. - Toileting: transferring on and off the toilet, use of bedpan, urinal or commode; cleansing after elimination; changing any protective pads; adjusting clothing after toileting. Policy titled Resident dignity rehab/skilled dated 10/6/20, indicated -To maintain the dignity of all residents -To promote encourage support enhance the residents self esteem -To promote a sense of self worth -To assist with respecting and abiding their residents rights Policy: -The location will promote care for residents and a manner in an environment that maintains or enhances each residence dignity and respect in full recognition of his or her individuality. -Encouraging and assisting resident to dress in their own Clothes appropriate to the time of day and individual preference is, rather than hospital type gowns.	F 550		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		10/8/21

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F 688	Continued From page 5 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a range of motion program for upper extremities was implemented for 2 of 2 residents (R4, R35) reviewed who had limited range of motion. Findings include: R4's face sheet, printed 8/25/21, identified diagnoses of hemiplegia (paralysis) following cerebrovascular (condition that affects blood flow to the brain) disease event affecting left non-dominant side. R4's annual Minimum Data Set (MDS) assessment dated 5/21/21, identified R4 had intact cognition, limited range of motion of both upper and lower extremities on one side and required extensive assist of 2 or more persons for	F 688	F-688 Correction Order #2895 Corrected Date: October 8, 2021 It is the current policy and procedure of GSS-Windom to provide ROM as needed to residents. On Aug. 30, 2021, R4 was referred to therapy, who assessed and applied a splint on Aug. 30, 2021. The care plan and treatment record were updated to reflect the new splint. For R35, on Sept. 22, 2021, the functional maintenance program was revised to reflect current needs. The revised program was attempted for 1 week with poor outcomes. R35 was then referred	

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F 688	Continued From page 6 transfers, bed mobility and toileting and extensive assist of one for personal hygiene. R4's care plan, dated 9/30/19, and last updated 7/22/21, indicated R4 had a need for a functional maintenance program due to deficit and limited physical mobility related to left hemiplegia and needing assistance with transfers and ambulation. Interventions included active range of motion to include NuStep (recumbent cross train exercise machine) two times per week and ambulate with 1 assist and wheelchair to follow at distance R4 can tolerate as needed. There was no plan of care addressing passive ROM or R4's left upper extremities. During observation and interview on 8/23/21, at 3:16 p.m., R4 was sitting in a recliner with left hand lying on her lap, with thumb, middle finger and 5th finger bent towards the palm of the hand but not touching. Upon request R4 was unable to move her left fingers, hand or arm without assistance from her right hand. R4 indicated they do not do any ROM on her left hand or fingers nor does she have a splint. R4 further stated her left leg works better than her arm and does not recall having therapy for her upper extremity, but just finished physical therapy for transfers and walking. During observation and interview on 8/25/21, 7:34 a.m., R4's left thumb, middle, and 5th finger were bent in towards the palm of her hand. R4 indicated she does not recall therapy ever working with her hand since she has been at this facility. R4 confirmed she has never had nor worn a splint on her hand. R4 stated the doctors told her after a year from her stroke she would not regain any mobility.	F 688	back to therapy on Sept. 30, 2021 for further assessment. All clients at risk for contractures were evaluated for additional service needs. Appropriate care plan updates were completed by the Case Managers Sept. 29-Oct. 1, for anyone found to be at risk. All clients on functional maintenance services are at risk for this deficient practice. All functional maintenance programs were assessed and updated as needed Sept. 29-Oct. 1, 2021 by the Director of Nursing and the Case Managers. To prevent further potential deficient practice, all nursing staff were re-educated Oct. 4-8, 2021, through learning boards and a post-quiz developed by the Administrator, Director of Nursing, and a Case Manager, regarding the importance of completing ROM programs and contractures. The case managers will be re-educated and will complete a post-quiz on Oct. 5, 2021, by the Director of Nursing, regarding functional maintenance programs and hand contractures per GSS policy and procedure. A random audit of Functional Maintenance ROM programs will be conducted by the QAPI Coordinator or designee, 1 time weekly for 12 weeks with the care planning schedule. A random audit of those with potential for contractures will be conducted 1 time weekly for 12 weeks with the care planning schedule. Audit	

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F 688	Continued From page 7 During interview on 8/25/21, at 8:24 a.m., occupational therapist (OT) indicated she has not worked with R4 and after searching documentation stated R4 has never had a referral or had occupational therapy. OT indicated R4 recently had physical therapy but referral was only for lower extremity. OT indicated if fingers are bending towards the palm of her hand, ROM and a splint could prevent further contracture but a referral is needed for them to work with R4. Upon interview on 8/25/21, at 8:28 a.m., nursing assistant (NA)-A indicated she does restorative therapy (RT) and R4 generally walks in the hallways on Monday, Wednesday and Friday and rides the NuStep Tuesday and Thursday. NA-A indicated she does not exercise either of her hands but indicated she thinks R4 sometimes does it herself. During interview on 8/25/21, at 8:54 a.m., NA-B indicated NA's are not responsible for providing ROM services as they have a restorative aide to do that. NA-B further indicated R4 used to have a splint but she has not seen it for awhile. During interview on 8/25/21, at 8:57 a.m., registered nurse (RN)-I case manager indicated she recently gave R4 a denial for therapy for her lower leg, and per documentation it doesn't look like they worked with her left hand. RN-I indicated she was aware of contractures on R4's left hand and would complete a referral today for OT. During interview on 8/25/21 at 9:33 a.m., NA-A indicated she does restorative therapy from 10:00 a.m. until 2:00 p.m., but doesn't always get all the	F 688	results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 688	Continued From page 8	F 688		

residents completed. The rest of her hours are spent providing direct patient care.

During interview on 8/26/21, at 9:42 a.m., the director of nursing (DON) confirmed R4 has not had any therapy on her left hand since admission. The DON indicated once contractures started they will generally complete a referral for therapy. DON stated RN-A thought physical therapy would look at it during her recent therapy, but the DON informed RN-A that occupational therapy is responsible for hands and fingers. The DON indicated obviously this was something no one noticed.
R35

R35's facesheet printed on 8/26/21, included diagnoses of major depressive disorder, dementia, anxiety and high blood pressure.

R35's quarterly Minimum Data Set (MDS) assessment dated 7/23/21, indicated R35 was cognitively intact, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R35 required supervision of one staff for bed mobility, transfers, walking and eating. Required limited assistance of one staff for toileting, and extensive assistance one staff for dressing and hygiene.

R35's progress note, dated 7/21/21, indicated R35 was seen by a physician for a 60-day nursing home check. Physician note indicated R35's right shoulder was stiff and R35 was having more difficulty with mobility. Previously was doing well after physical therapy due to right humerus fracture. Okay for OT (occupational therapy) order for restorative cares due to decreasing mobility and strength.

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F 688	Continued From page 9 R35's physician orders dated 7/21/21, indicated OT was to evaluate and treat as indicated for arm strength and shoulder ROM (range of motion). Diagnosis: history of humerus fracture, right arm. R35's care plan with initiated date of 4/21/21, indicated ADL (activity of daily living) self care deficit related to weakness secondary to history of left humerus fracture evidenced by inability to independently dress, groom, bathe and toilet self. R35 would maintain at current level of functioning and ADL score though the review process. Interventions did not identify ways in which to current level of functioning and ADL score would be maintained. Interventions identified how many staff were needed to assist R35 with various activities, such as bathing, bed mobility, dressing, eating. R35's progress note dated 7/19/21, written by director of nursing (DON) indicated functional maintenance program reviewed. Referral in progress to skilled therapy to evaluate upper extremities and shoulders for possible exercise program. R35's progress note dated 7/21/21, written by registered nurse (RN)-C indicated physician had been there and wrote a new order for OT to evaluate and treat as indicated for ROM and strengthening in arm/shoulder. R35 progress note dated 7/27/21, written by DON indicated waiting for OT orders for upper extremity evaluation and set up for functional maintenance program. Care plan with initiated date of 1/6/21, indicated	F 688		

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F 688	Continued From page 10	F 688		

R35 had a need for functional maintenance intervention to maintain strength and prevent falls. On 7/22/21, the care plan was revised to include: Active range of motion for ambulation every day PRN (as needed).

Care conference note dated 8/5/21, written by (RN)-B indicated R35 remained on a functional rehabilitation program without concerns.

R35's progress note dated 8/6/21, written by DON indicated skilled OT had made recommendations to update residents functional maintenance program which were to include exercises for upper extremity.

Care plan with initiated date of 1/6/21, was revised on 8/6/21, to include:
1. Active range of motion: seated bilateral upper arm exercises with a dowel. 10 repetitions two times, PRN.
2. Active range of motion: NuStep (recumbent cross trainer equipment) for 5 minutes to promote ROM. Settings tolerated PRN.

R35's progress note dated 8/17/21, by (RN)-I indicated OT completed an evaluation and would update R35's restorative program.

During an interview on 8/23/21, at 2:41 p.m., R35 stated she used to get therapy and exercises for "frozen shoulders," but not anymore, adding she would like to have therapy again. R35 stated her shoulders were stiff and she couldn't do things for herself without a lot of pain.

During an interview on 8/25/21, at 7:49 a.m., nursing assistant (NA)-C stated she and (NA)-A provided restorative services to residents, but had

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	245558	A. BUILDING _____ B. WING _____	C 08/26/2021

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F 688	Continued From page 11	F 688		

not been providing services to R35 that she was aware of. NA-C stated she started the day caring for residents, then switched to restorative services at 10:00 a.m.; however was not always able to do that if needed on the floor.

During an interview on 8/26/21, at 11:32 a.m., reviewed functional maintenance (the facility used this term rather than restorative services) form for R35 with the DON. The only date exercises had been done with R35 since the new order on 7/21/21, were on 8/8/21. The DON stated she would have expected it to have been more times; she expected it to be done daily, Monday through Friday unless a resident declined or refused, then she expected that to be documented. Informed there were no refusals documented for R35. When asked what PRN meant in relation to care plan interventions for R35, for example: Active range of motion: seated bilateral upper arm exercises with a towel. 10 repetitions two times, PRN, the DON stated it meant exercises where not scheduled on a specific day of the week for flexibility purposes, but she still expected them to be done daily Monday through Friday. The DON stated she did not know why R35's exercises had not been done - no one had informed her of this, and acknowledged physician orders needed to be carried out. The DON agreed that in this case, R35 needed exercises to maintain strength and prevent her shoulders from becoming stiff. The DON stated two NA's provided functional maintenance to residents and were available Monday through Friday. The DON admitted exercises might not get done if the NA's were not able to switch from NA work to functional maintenance work, but that would not happen often.

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F 688	Continued From page 12 Facility policy titled "Restorative Functional Exercise" dated 4/6/21 included: Purpose: - to assess and instruct in endurance, strength, coordination, dexterity, activity tolerance, postural control, neck, trunk, upper and lower extremity range of motion and safety in all areas (all areas relate to ability/independence in activities of daily living) - to maintain muscle tone, strength and joint function - to prevent deformities caused by inactivity of a part - to help maintain normal physiologic function of all body systems - to increase strength, range of motion, coordination, activity tolerance and postural control for fall prevention, circulation and skin integrity.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		10/11/21

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F 692	Continued From page 13 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act when recommendations from the registered dietitian were identified but not implemented for 1 of 1 residents (R35) with weight gain. Findings include: R35's facesheet printed on 8/26/21, included diagnoses of major depressive disorder, dementia, anxiety and high blood pressure. R35's quarterly Minimum Data Set (MDS) assessment dated 7/23/21, indicated R35 was cognitively intact, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R35 required supervision of one eating, and had a weight gain of 5% or more in last month or 10% or more in last 6 months. R35's physician orders dated 6/26/21, included monitoring for side effects of antidepressant, such as changes in weight and to monitor for effects of antipsychotic medication such as weight gain. R35's care plan with initiated date of 4/28/21, indicated R35 had an unplanned weight gain related to overeating, evidenced by weight gain; that R35 would express satisfaction with following the recommended portion size of snacks through	F 692	F-692 Correction Order #2965 Corrected Date: October 11, 2021 It is the current policy and procedure of GSS-Windom to monitor resident weights. R35 was re-assessed and their care plan updated regarding weight gain by the Dietician and Director of Food and Nutrition on Aug. 25, 2021. All residents are at potential risk for this deficient practice. A weight gain audit was conducted the Dietician and the Director of Nursing on Sept. 29, 2021, with the care plans of any additional residents with weight gain addressed. On Oct. 11, 2021, an audit of all dietary recommendations for September will be conducted by the Dietician and the Director of Nursing, to assure they were implemented. To prevent further potential deficient practice, the dietician will give diet recommendations to the case managers/Director of Nursing. A doctor's order will be obtained and when returned, a diet change form will be processed per GSS procedure. From the info on the diet change form, the dietary director will update the diet card and provide the change information to the dietary	

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F 692	Continued From page 14 the review date. Interventions included talking to R35 and her family about healthier snack options and portion size of snacks; coping behaviors, alternatives to over-eating, feelings related to food, adverse effects of weight gain. During an interview on 8/23/21, at 2:45 p.m., when asked if she had experienced weight loss or weight gain, R35 stated she had gained weight, but didn't know how much. When asked if she was concerned about that, she stated, "well, I don't want to gain anymore." R35's measured weights indicated a 12.41% weight gain in six months, from 145 pounds on 2/24/21, to 163 pounds on 8/23/21. Nutritional status progress note dated 4/25/21, and written by registered dietician (RD)-G, indicated R35 was on a regular diet, had no chewing or swallowing problems and was able to feed herself. R35's weight was 152 pounds, showing a gradual and persistent weight gain since admission in April 2020, and now a significant weight gain of 18 pounds (13.4%) in the past six months. R35's BMI was up to 31.8 (considered obese). MNA (mini nutritional assessment) score was 13, indicating normal nutritional assessment. The dietician note recommended talking to her family about her significant weight gain and recommended decreasing calorie intake, either by providing smaller portions in general, or by starting some specific lower calorie interventions. Interventions could include no bread at meals unless the menu is a sandwich, smaller portions of potatoes, smaller portions of desserts, lower calorie snack choices between meals and making sure to offer calorie free beverages between meals.	F 692	department via the dietary communication book. The Dietician and Director of Dietary will educate and proctor a post-quiz to the dietary employees on Oct. 11, 2021 regarding this process. The Director of Nursing will educate and proctor a post-quiz to the case managers on Oct. 11, 2021 regarding this process. Additionally, the case managers will be re-educated and will complete a post-quiz on Oct. 5, 2021, by the Director of Nursing, regarding the monitoring of weights and appropriate follow-up per GSS policy and procedure. An audit of dietician recommendations will occur to assure appropriate and timely follow-up, will be conducted by the QAPI Coordinator or designee, will occur 1 time weekly for 12 weeks with the care planning schedule. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 692	Continued From page 15	F 692		

R35's diet card was reviewed. Serving size choices on the card were small, medium and large and medium was checked. No recommendations by the dietician from 4/25/21, were noted on the card.

During a telephone interview on 8/25/21, at 9:24 a.m., RD-G reviewed her care conference notes from April 2021, and stated "I supposed you're wondering if my recommendations were acted upon? I don't watch weight gains as closely. I give my recommends in writing to the DON and dietary. You should be able to look at those to see if they were followed through."

During an interview on 8/25/21, at 9:36 a.m., dietary supervisor (DS)-E located two sets of dietician notes dated 4/5/21, and 4/28/21, adding that RD-G reviewed resident nutrition status twice a month. The documents were titled Medical Records Reviewed by Consultant Dietician, and were in grid format with columns for residents name, nutrition problem, nutrition recommendation and follow-up columns for notification of all necessary staff. RD-G's recommendations were hand-written. R35 was not listed on either document. DS-E stated she was not aware of any recommendations for R35 from RD-G from April.

On 8/25/21, at 10:28 a.m. RD-G called back and stated she had been working remotely in April so would have sent the director of nursing (DON) an email about R35's weight gain and recommendations.

During an interview 8/25/21, at 10:50 a.m., the DON did not recall receiving an email from RD-G

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F 692	Continued From page 16 regarding R35. The DON looked back in her emails and stated she did not have an email regarding R35 from the RD-G. The DON stated any recommendations by RD-G for R35 from 4/25/21, had not been communicated to dietary or nursing and therefore had not been implemented. During an interview 8/25/21, at 10:56 a.m., DS-E stated she spoke to R35 and R35 stated she would like smaller portions and agreed she didn't want to gain any more weight, and would be okay trying smaller portions at meal times. During an interview on 8/26/21, at 11:32 a.m., the DON had not been aware of R35's weight gain until 8/25, adding that RD-G's recommendations should have been followed through when R35's significant weight gain had been identified in April. The usual process for this was the dietician communicated recommendations in writing to dietary and to the DON in order for recommendations be carried out; e.g., added to the diet card and resident's care plan. The DON stated that process did not happen this time and could not explain why. Facility policy titled Responsibilities of the Dietician - Food and Nutrition Services, dated 6/17/21, indicated the dietician reviewed all reports and resident records pertinent to the resident nutrition status, such as weight. The dietician provided written reports to the facility monthly regarding recommendations. The dietician reviewed recommendations with the DON at each visit.	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		10/11/21

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F 758	Continued From page 17 §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--- §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	F 758		

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F 758	Continued From page 18 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 timely gradual dose reduction (GDR) of a psychotropic medication was attempted or rationale provided for current dose justification for 1 of 5 residents (R57) reviewed for unnecessary medication use. Findings include: R57's Admission Record printed 8/25/21, indicated diagnosis including major depressive disorder and dementia without behavioral disturbance. R57's change of condition Minimum Data Set (MDS) assessment dated 8/24/21, identified R57 has severely impaired cognition, exhibited no behaviors, and scored a 4/27 on Patient Health Questionnaire (PHQ)-9 (Major depressive disorder module used to diagnose depression), completed by staff and indicating minimal symptoms of depression. R57's "Consultant Pharmacist Communication to Physician" dated 4/25/21, included R57 was admitted 11/2/20 with an order for escitalopram (used to treat depression) 10 mg daily for major depressive disorder, which falls under gradual dose reduction guidelines. This includes agents	F 758	F-758 Corrected Date: October 11, 2021 It is the current policy and procedure of GSS-Windom to review residents for unnecessary medication use. The physician for R57 had reviewed the consultant pharmacist communication and adjusted the medication on July 21, 2021. All residents are at risk for this deficient practice. All resident consultant pharmacist communications from Aug. 30, 2021, were reviewed by the Director of Nursing and Case Managers on Sept. 29, 2021 for an outstanding medication recommendations. None were found. To prevent further potential deficient practice, the Director of Nursing who receives the pharmacy reports, will coordinate the dissemination of the recommendations to the physicians within the required time frame. The Case Managers will be re-educated and will complete a post-quiz by the Director of Nursing on Oct. 5, 2021, and Oct. 11, 2021, regarding appropriate and	

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F 758	Continued From page 19 within the antidepressant category. The provider response to this communication, undated, included escitalopram 5 mg daily however a written order did not occur until after 7/13/21 or written justification to continue medication at same dose. R57's Physician Orders dated 5/21/21 included escitalopram oxalate Tablet 10 mg daily. R57's Physician Orders dated 6/21/21 included escitalopram oxalate Tablet 10 mg daily. R57's Physician Orders dated 7/21/21 included escitalopram oxalate Tablet 5 mg daily. R57's plan of care, last revised 2/3/2021 included the resident is on medications with Federal Drug Agency boxed warnings or warning of adverse consequences related to depression. A Medication Record for 5/1/21 through 7/13/21 indicated escitalopram oxalate 10 mg was given orally daily through 7/13/21. During interview on 8/26/21, at 8:50 a.m., the director of nursing indicated unless the pharmacist marks urgent we wait until the medication review to address the recommendations however DON indicated this time did seem longer than usual. During interview on 8/26/21, at 9:21 a.m., the consultant pharmacist indicated this was a longer time period to reduce the dose than normal. A policy titled "Psychotropic Medication Use Policy and Procedure" dated 9/19 included:	F 758	timely follow-up for the consultant pharmacist recommendations to physicians per GSS policy and procedure. An audit of the consultant pharmacist recommendations to physicians to ensure timely response and follow-up will be conducted by the Health Information Manager or designee, 1x monthly times 4 months. The audit will occur at the end of each month for recommendations received at the end of the previous month to assure timely follow-up. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 758	Continued From page 20 - Each resident's drug regimen must be free from unnecessary drugs. -Gradual Dose Reductions: - The purpose of tapering medication is to find an optimal dose or to determine if continued use of the medication is benefiting the resident. Tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolve and/or non-pharmacological interventions have been effective in reducing the symptoms.	F 758		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;	F 790		10/11/21

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F 790	Continued From page 21 §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental recommendations were acted upon and future appointments coordinated to ensure timely service for 1 of 1 residents (R30) reviewed for dental care. Findings include: R30's facesheet printed 8/24/21, included diagnoses of Parkinson's Disease (progressive nervous system disorder that affects movement) and diabetes (metabolic disorder in which the body has high sugar levels for prolonged periods of time). R30's significant change Minimum Data Set (MDS) assessment dated 7/9/21, indicated R30 had moderate cognitive impairment, minimal difficulty hearing, adequate vision, clear speech, was able to make self understood and could understand others. The MDS further identified no	F 790	F-790 Correction Order #21325 Corrected Date: October 11, 2021 It is the current policy and procedure of GSS-Windom to follow-up on dental referrals in a timely manner. A dental appointment was re-scheduled for R30 on Sept. 21, 2021. All clients are at risk for this deficient practice. On Sept. 30, 2021, the Director of Nursing and Case Managers reviewed all client records for unmet dental referrals and no others were found. To prevent further potential deficient practice, the Case Managers will track dental appointments via the nurse order system in PCC, which can generate a reminder order for follow-up on a date you choose.	

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F 790	Continued From page 22 dental problems, including broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable or loose) or obvious or likely cavity or broken natural teeth. R30's plan of care intervention with revised date of 7/22/21, indicated R30 needed set up/supervision for oral care. Plan of care intervention with revised date of 8/10/21, indicated R30 used a divided plate and plastic silverware when eating. No mention of dental status. During an interview and observation on 8/23/21, at 4:14 p.m., R30 had missing and broken teeth on the bottom of his mouth and a full denture on the top. R30 stated, "I need a new set of dentures on top, they're chipped." R30 removed and displayed his full upper denture. Then added "they won't take me to the dentist," he had asked, but was told they were "full up." A clinic referral form dated 2/17/21, indicated R30 had attended a routine dental appointment that day. Progress notes hand-written by dental staff indicated R30 had had an initial exam, xrays and a filling. Notes indicated a referral was made to oral surgery for extraction of tooth #20; and following extraction, teeth would be added to his partial denture. Lastly, the facility was to call to make an appointment after the extraction. R30's quarterly oral/dental assessment dated 4/6/21, indicated R30 had a partial lower bridge and full upper denture and had a pending [dental] appointment. A copy of an electronic note dated 4/14/21, from oral surgery indicated R30 had an odentectomy	F 790	The Case Managers will be re-educated and will complete a post-quiz by the Director of Nursing on Oct. 5, 2021, and on Oct. 11, 2021, regarding appropriate and timely follow-up of dental appointments and the new process of entering a future doctor's order for dental appointments which provides a mechanism to assure is follow-up is completed. An audit of dental referrals and appropriate follow-up will be conducted by the QAPI Coordinator or designee, 1x weekly for 12 weeks with the care planning schedule. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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	245558	A. BUILDING _____ B. WING _____	C 08/26/2021

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F 790	Continued From page 23	F 790		

(tooth removal) of tooth #20, and follow up instructions included to continue local dentist follow-up.

R30's care conference note dated 4/29/2021, at 10:37 a.m. indicated attendance by R30's daughter (via phone), registered nurse (RN)-A, recreation/wellness (RW)-A, licensed social worker (LSW)-A. R30 declined to attend. Care conference note indicated R30 saw the dentist a couple weeks ago and had teeth extracted. R30 was in need of a new denture plate as his denture plate went missing some time ago. R30's daughter was not concerned since R30 would likely be getting a new plate anyway since teeth were extracted.

R30's annual oral/dental assessment dated 7/6/21, indicated R30 had a partial upper bridge and a partial lower bridge and had a pending appointment for follow-up dental work.

During an interview on 8/24/21, at 2:28 p.m., administrative receptionist (AR)-F who made appointments for residents was asked if R30 had a dental appointment scheduled. AR-F looked in a folder and stated no, he did not have a dental appointment scheduled. AR-F presented a form titled: Appointment and Ride Request Intake, completed by RN-A which indicated resident and daughter requested a dental appointment as soon as possible. The form was not dated. There was a hand-written notation in pencil: "Eyes 1st Aug 4th." AR-F stated R30 wanted to wait till until after his eye appointment on 8/4/21, to go to the dentist, but then R30 canceled his eye appointment. AR-F stated after the eye appointment had been canceled on 8/4, the dental appointment had not been scheduled.

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F 790	Continued From page 24 AR-F had not been aware that R30's 2/17/21, dental instructions indicated the facility was to make another appointment after his tooth was extracted, and his tooth was extracted on 4/14/21. During an interview on 8/26/21, at 10:58 a.m., the DON stated she had not been aware of the sequence of events that occurred with R30's dental appointments until this day, but was aware AR-F had just made a dental appointment for R30. "It seems it should have been made sooner." When asked who reviewed dental notes to act upon follow-up instructions by the dentist, the DON stated nurses would do that and let AR-F know to make the appointment. DON was not sure what happened this time that the ball was dropped. The DON stated RN-A, who completed the Appointment and Ride Request Intake form had not worked since early July 2021, so the form which indicated R30 and his daughter had requested a dental appointment as soon as possible, would have been filled out in early July or earlier than that. The DON confirmed the appointment should have been made sooner, following the dentist's instructions. No facility policy was provided on making appointments for residents.	F 790		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		9/29/21

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F 812	Continued From page 25 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly maintain food to the appropriate temperature to ensure food safety and prevent foodborne illness. This deficient practice had the potential to affect all 60 residents, staff and visitors receiving food from the kitchen. Findings include: During observation on 8/24/21, at 11:20 a.m., cook (C)-A indicated he had taken the chicken out of the oven "awhile ago" and placed it in the steam table, but was unable to state the exact time. C-A stated he checked the temperature of the chicken and documented in the "food temperature" book, which indicated 180 degrees Fahrenheit (F) with no time present. C-A indicated he checks the temperature of the food about 20 minutes prior to serving food in the steam table and stated he had checked the temperature about 15 minutes prior to my arrival in the kitchen and the chicken temperature was 180 degrees F.	F 812	F-812 Corrected Date: Sept.29, 2021 It is the current policy and procedure of GSS-Windom to take food temperatures in accordance with regulations. On Aug. 24, 2021, when the food was found to not be at the appropriate temperature, the food was immediately placed back in the oven for further cooking, until it reached the proper temperature. All meals are at risk for this deficient practice. The Director of Food and Nutrition, with assistance from the Dietician, updated the mealtime food temperature log to include time the temperature was taken. They also updated the food temperature procedure to include additional temperature taking times, such as between loading the trays into the carts.	

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F 812	Continued From page 26 Prior to plating food on 8/24/21, at 11:23 a.m., per request, C-A checked temperature of chicken, which was 110 degrees F. C-A rechecked chicken temperature in another location and it was 124 degrees F. C-A indicated he will have to place it back in the oven and proceeded to do so. During observation and interview on 8/24/21, at 11:36 a.m., C-A removed the chicken from the convection oven and rechecked temperature which was 115 degrees F. There was no steam present when uncovered. C-A then placed chicken back into the convection oven and indicated the oven had been off so likely wasn't very hot when initially placed in the oven. During observation and interview 8/24/21, at 11:49 a.m., C-A removed chicken from the convection oven with temperature at 128 degrees F. C-A tried two different thermometers stating maybe the thermometer was not accurate with no change in temperature. Observed no steam coming from pan of chicken. C-A then indicated they have been having some issues with the convection oven so placed chicken back in regular oven. During observation and interview 8/24/21, at 12:05 p.m., C-A removed chicken from the oven and upon checking temperature of chicken it read 190 degrees F. Steam was present coming from the pan of chicken. Upon request on 8/24/21, at 12:32 p.m., C-A rechecked temperature of chicken prior to moving steam table to main dining room with temperature at 165 degrees F. C-A confirmed he would not have checked the temperature prior to beginning	F 812	To prevent further potential deficient practice, the cooks were educated on Sept 29, 2021, by the Director of Food and Nutrition and the Consulting Dietician regarding GSS policy and procedure for taking and recording food temperatures. The proper completion of food temperature logs will be audited 3 times weekly times 4 weeks and then 1 time weekly for 8 weeks by the Director of Food and Nutrition or designee. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 812	Continued From page 27 serving the chicken from the steam table as he had done so 20 minutes prior to my arrival. Review of food temperature monitoring log on 8/24/21, at 12:41 p.m., did not include time, or food product checked but all cold temperatures were below 38 degrees and all hot foods were 165 degrees F or higher since the beginning of the August. During interview on 8/26/21, at 11:11 a.m., the dietary supervisor (DS) indicated temperatures should be checked immediately prior to serving the foods. A policy and procedure titled "Food temperature Monitoring" dated 4/14/21, included: - Food temperatures are taken and recorded before each meal service. Periodically, temperatures are taken at other times during or at the end of meal service to ensure temperatures are held within acceptable ranges. - Chicken, turkey, stuffing, stuffed meats, stuffed pasta, stuffed poultry heating temperature is 165 degrees instantaneous - Hot foods should be served at 135 degrees F or higher.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		10/8/21

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F 880	Continued From page 28 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 29 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing measures to prevent the spread of COVID-19 when the facility failed to ensure personal protective equipment (PPE) including mask worn correctly, and when the facility failed to separate an unvaccinated resident from vaccinated residents at meal time. This had the potential to affect all 60 residents who resided in the facility. Findings include: Unvaccinated Resident During entrance conference on 8/23/21, at 1:55 p.m., was informed that one resident in the	F 880	F-880 Correction Order #21375 Corrected Date: October 8, 2021 On Aug. 24, 2021, R46 was placed at a personal table, 6 feet away from other residents, but facing them. This arrangement continues. Staff on duty at the time of the incident were immediately re-educated by the Activity Director and the Director of Nursing. No other residents at the time of survey were unvaccinated. One short-term client is currently unvaccinated and their dining situation follows appropriate guidelines. All staff present on Aug. 23, 2021, were immediately re-educated regarding proper mask use and were provided with a	

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F 880	Continued From page 30 facility, R46, was not vaccinated for Covid-19. During an observation on 8/23/21, at 5:57 p.m., R46 was observed eating at a small square table, approximately 4 feet by 4 feet, in the nurses station dining room. At the table with R46 was R25 and R30. None of the residents were masked. During an interview and observation on 8/24/21, at 8:50 a.m., observed R46, the facility's only unvaccinated resident, eating at a small, square table in the nurses station dining room with two other residents, R25 and R30. Licensed practice nurse (LPN)-B stated she did not know if there were any unvaccinated residents in the facility; she would have to call the front desk to find out. LPN-B was not sure if vaccinated and unvaccinated residents could eat together at the same table and would have to ask the DON. During an interview on 8/24/21, at 8:52 a.m. (RN)-I stated there was only one resident on the north side who had not been vaccinated for Covid-19 and that was R46. RN-I confirmed R46 was eating breakfast at a table in the nurses station dining room with R25 and R30. When asked if it was okay for an unvaccinated resident to eat in close proximity to other residents, RN-I stated, "I don't know.....that's what we've always done." During an interview on 8/24/21, at 11:37 a.m., the DON was asked where the unvaccinated resident, R46, ate her meals. The DON stated she was aware of CDC guidance that unvaccinated residents should be six feet away from vaccinated residents when eating. The DON stated R46 was in a pattern of coming out of her	F 880	different style mask if needed to ensure proper fit. Any new unvaccinated residents would be at risk for this deficient practice. All clients upon admission are assessed for vaccination status and will dine in accordance with GSS policy and procedure aligning with current state and federal guidelines. All residents would be at risk for staff not wearing/using masks appropriately. A Root Cause Analysis was conducted on Sept. 22, 2021, by the QAPI committee, including the Infection Preventionist and was reviewed and approved by the Good Samaritan Society Nursing and Clinical Services Consultant and the Good Samaritan Society Quality Improvement Advisor. All policies and procedures for PPE usage during the COVID-19 pandemic, including source control masks, proper use of gowns, and transmission-based precautions, were reviewed and found to be appropriate. To prevent further potential deficient practice of unvaccinated resident dining, clients who are unvaccinated will dine in accordance with the current CMS QSO-20-39-NH. Notice of these clients is posted at the nurse's stations on which they reside, as well as outside their room door with a purple precautions sign. All staff were re-educated Oct. 4-8, 2021, through learning boards and a post-quiz developed by the Administrator, Director	

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F 880	Continued From page 31 room and going to that table. "It would be hard to accommodate...need to look at the bigger picture...likes to eat at the table and she doesn't stay long." The DON stated she would talk to her team about other options. During an observation on 8/24/21, at 12:54 p.m., observed R46 eating at a table by herself in the nurses station dining room, at least six feet away from a table with R25 and R30. Another table had been set up for R46, and the table had a placard with her name on it in the center of the table. R46 was not isolated and was still able to see and hear other residents and staff. Facility policy titled Covid 19 Guidance: Long-term Care Indoor Visitation for Nursing facilities and Assisted Living-type settings from the State department of health, dated 5/20/21, indicated if unvaccinated residents are present during communal dining or activities, then all residents should use face coverings when not eating, and unvaccinated residents should physically distance from others Mask Observations On 8/23/21, the following mask observations were made: of staff and visitors in the facility who were not appropriately wearing face masks. At 1:42 p.m., administrative receptionist (AR)-F was observed with mask below nose. At 1:38 p.m., the director of nursing (DON) was observed with mask below nose. At 2:31 p.m., nursing assistant (NA)-D was observed with mask below nose. At 3:19 p.m., DON was observed to continue to wear mask below nose. At 3:30 p.m., registered nurse (RN)-J was	F 880	of Nursing, and a Case Manager, regarding the current requirements for unvaccinated resident dining and the system for knowing who is unvaccinated. To prevent further potential deficient practice of mask wearing, all employees were re-educated through lecture, demonstration, and competency testing, by the Clinical Learning and Development Specialist on Sept. 28-30, 2021, regarding standard infection control practices, including transmission-based precautions, appropriate PPE use, and donning and doffing PPE. Residents and their representatives will be educated via email/postal mail/room delivery on Oct. 1, 2021, and in person on Oct. 6, 2021, at the Resident Council by the Administrator and Infection Preventionist regarding the facility infection control program, including visitor responsibilities. Any unvaccinated resident dining situations will be randomly audited by the QAPI Coordinator or designee, 3 times per week at various meals for 4 weeks, then 1 time per week for 8 weeks. The QAPI Coordinator and designees will audit in the following manner. A minimum of 10 times per week for 4 weeks, then 5 times per week for 8 weeks or until compliance is sustained; covering multiple shifts and multiple departments. People audited will include, employees, visitors, and residents. Items to be audited include, but are not limited to: donning and doffing of PPE with transmission-based precautions,	

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F 880	Continued From page 32 observed with mask below nose. At 3:30 p.m., maintenance (M)-A was observed with mask below nose. At 5:45 p.m., (NA)-E was observed with mask below nose. At 5:50 p.m., While in R47's room, observed activities (A)-B bend forward at the waist, directly in front of R47 in his wheelchair, about one foot from his unmasked face and pull down her mask below her chin to talk to him about supper. At 6:11 p.m., observed a female visitor of a resident in the dining room on the 500 wing, feeding him, wearing mask below her nose. At 6:27 p.m., observed NA-E in the dining room of the 500 wing assisting a resident to eat. Mask was below chin. When saw surveyor, pulled mask up to below nose. During an interview on 8/23/21, at 6:40 p.m.., the director of nursing (DON) and administrator were asked what the expectation was for staff wearing masks, was it okay for them to be worn below the nose. The DON stated no, it was not acceptable -- it was not the correct way to wear a mask for infection control purposes. The DON stated masks did not stay up on her face, as she manipulated it while talking. The administrator stated they would look into it. During an observation on 8/23/21, at 7:01 p.m., observed DON with a different style surgical mask on. The mask was observed to be yellow, not blue. The DON stated they found some additional masks and these were better fitting for her. The mask was observed to be worn properly. During an observation on 8/23/21, at 7:10 p.m., observed the DON handing out masks to some staff and speaking to them about wearing masks	F 880	aerosolized generating procedures to ensure PPE is used, and proper use of PPE gowns. All audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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F 880	Continued From page 33 properly. Facility policy titled Covid-19 Guidance: Long-term Care Indoor Visitation for Nursing facilities and Assisted Living-type settings from the State department of health, dated 5/20/21, indicated staff were to wear a well-fitting facemask that fully covers the mouth and noise, in accordance with CDC guidance. residents should physically distance from others.	F 880		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 21, 2021

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

Re: State Nursing Home Licensing Orders
Event ID: PELM11

Dear Administrator:

The above facility was surveyed on August 23, 2021 through August 26, 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, Minnesota 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
	00085	A. BUILDING: _____ B. WING _____	C 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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
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 8/23/21, to 8/26/21, a licensing 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 have reviewed	2 000		

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2 000	Continued From page 1 these orders, and identify the date when they will be completed. The following complaint were found to be UNSUBSTANTIATED: H5558028C (MN00051263), H5558027C (MN00058952). 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 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.	2 000		

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2 000	Continued From page 2 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		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a range of motion program for upper extremities was implemented for 2 of 2 residents (R4, R35) reviewed who had limited range of motion. Findings include: R4's face sheet, printed 8/25/21, identified diagnoses of hemiplegia (paralysis) following	2 895	Correction Order #2895 Corrected Date: October 8, 2021 It is the current policy and procedure of GSS-Windom to provide ROM as needed to residents. On Aug. 30, 2021, R4 was referred to therapy, who assessed and applied a splint on Aug. 30, 2021. The care plan	10/8/21

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2 895	Continued From page 3 cerebrovascular (condition that affects blood flow to the brain) disease event affecting left non-dominant side. R4's annual Minimum Data Set (MDS) assessment dated 5/21/21, identified R4 had intact cognition, limited range of motion of both upper and lower extremities on one side and required extensive assist of 2 or more persons for transfers, bed mobility and toileting and extensive assist of one for personal hygiene. R4's care plan, dated 9/30/19, and last updated 7/22/21, indicated R4 had a need for a functional maintenance program due to deficit and limited physical mobility related to left hemiplegia and needing assistance with transfers and ambulation. Interventions included active range of motion to include NuStep (recumbent cross train exercise machine) two times per week and ambulate with 1 assist and wheelchair to follow at distance R4 can tolerate as needed. There was no plan of care addressing passive ROM or R4's left upper extremities. During observation and interview on 8/23/21, at 3:16 p.m., R4 was sitting in a recliner with left hand lying on her lap, with thumb, middle finger and 5th finger bent towards the palm of the hand but not touching. Upon request R4 was unable to move her left fingers, hand or arm without assistance from her right hand. R4 indicated they do not do any ROM on her left hand or fingers nor does she have a splint. R4 further stated her left leg works better than her arm and does not recall having therapy for her upper extremity, but just finished physical therapy for transfers and walking. During observation and interview on 8/25/21, 7:34	2 895	and treatment record were updated to reflect the new splint. For R35, on Sept. 22, 2021, the functional maintenance program was revised to reflect current needs. The revised program was attempted for 1 week with poor outcomes. R35 was then referred back to therapy on Sept. 30, 2021 for further assessment. All clients at risk for contractures were evaluated for additional service needs. Appropriate care plan updates were completed by the Case Managers Sept. 29-Oct. 1, for anyone found to be at risk. All clients on functional maintenance services are at risk for this deficient practice. All functional maintenance programs were assessed and updated as needed Sept. 29-Oct. 1, 2021 by the Director of Nursing and the Case Managers. To prevent further potential deficient practice, all nursing staff were re-educated Oct. 4-8, 2021, through learning boards and a post-quiz developed by the Administrator, Director of Nursing, and a Case Manager, regarding the importance of completing ROM programs and contractures. The case managers will be re-educated and will complete a post-quiz on Oct. 5, 2021, by the Director of Nursing, regarding functional maintenance programs and hand contractures per GSS policy and procedure. A random audit of Functional Maintenance	

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2 895	Continued From page 4 a.m., R4's left thumb, middle, and 5th finger were bent in towards the palm of her hand. R4 indicated she does not recall therapy ever working with her hand since she has been at this facility. R4 confirmed she has never had nor worn a splint on her hand. R4 stated the doctors told her after a year from her stroke she would not regain any mobility. During interview on 8/25/21, at 8:24 a.m., occupational therapist (OT) indicated she has not worked with R4 and after searching documentation stated R4 has never had a referral or had occupational therapy. OT indicated R4 recently had physical therapy but referral was only for lower extremity. OT indicated if fingers are bending towards the palm of her hand, ROM and a splint could prevent further contracture but a referral is needed for them to work with R4. Upon interview on 8/25/21, at 8:28 a.m., nursing assistant (NA)-A indicated she does restorative therapy (RT) and R4 generally walks in the hallways on Monday, Wednesday and Friday and rides the NuStep Tuesday and Thursday. NA-A indicated she does not exercise either of her hands but indicated she thinks R4 sometimes does it herself. During interview on 8/25/21, at 8:54 a.m., NA-B indicated NA's are not responsible for providing ROM services as they have a restorative aide to do that. NA-B further indicated R4 used to have a splint but she has not seen it for awhile. During interview on 8/25/21, at 8:57 a.m., registered nurse (RN)-I case manager indicated she recently gave R4 a denial for therapy for her lower leg, and per documentation it doesn't look like they worked with her left hand. RN-I	2 895	ROM programs will be conducted by the QAPI Coordinator or designee, 1 time weekly for 12 weeks with the care planning schedule. A random audit of those with potential for contractures will be conducted 1 time weekly for 12 weeks with the care planning schedule. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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2 895	Continued From page 5	2 895		

indicated she was aware of contractures on R4's left hand and would complete a referral today for OT.

During interview on 8/25/21 at 9:33 a.m., NA-A indicated she does restorative therapy from 10:00 a.m. until 2:00 p.m., but doesn't always get all the residents completed. The rest of her hours are spent providing direct patient care.

During interview on 8/26/21, at 9:42 a.m., the director of nursing (DON) confirmed R4 has not had any therapy on her left hand since admission. The DON indicated once contractures started they will generally complete a referral for therapy. DON stated RN-A thought physical therapy would look at it during her recent therapy, but the DON informed RN-A that occupational therapy is responsible for hands and fingers. The DON indicated obviously this was something no one noticed.

R35

R35's facesheet printed on 8/26/21, included diagnoses of major depressive disorder, dementia, anxiety and high blood pressure.

R35's quarterly Minimum Data Set (MDS) assessment dated 7/23/21, indicated R35 was cognitively intact, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R35 required supervision of one staff for bed mobility, transfers, walking and eating. Required limited assistance of one staff for toileting, and extensive assistance one staff for dressing and hygiene.

R35's progress note, dated 7/21/21, indicated R35 was seen by a physician for a 60-day nursing

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2 895	Continued From page 6	2 895		

home check. Physician note indicated R35's right shoulder was stiff and R35 was having more difficulty with mobility. Previously was doing well after physical therapy due to right humerus fracture. Okay for OT (occupational therapy) order for restorative cares due to decreasing mobility and strength.

R35's physician orders dated 7/21/21, indicated OT was to evaluate and treat as indicated for arm strength and shoulder ROM (range of motion). Diagnosis: history of humerus fracture, right arm.

R35's care plan with initiated date of 4/21/21, indicated ADL (activity of daily living) self care deficit related to weakness secondary to history of left humerus fracture evidenced by inability to independently dress, groom, bathe and toilet self. R35 would maintain at current level of functioning and ADL score though the review process. Interventions did not identify ways in which to current level of functioning and ADL score would be maintained. Interventions identified how many staff were needed to assist R35 with various activities, such as bathing, bed mobility, dressing, eating.

R35's progress note dated 7/19/21, written by director of nursing (DON) indicated functional maintenance program reviewed. Referral in progress to skilled therapy to evaluate upper extremities and shoulders for possible exercise program.

R35's progress note dated 7/21/21, written by registered nurse (RN)-C indicated physician had been there and wrote a new order for OT to evaluate and treat as indicated for ROM and strengthening in arm/shoulder.

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2 895	Continued From page 7 R35 progress note dated 7/27/21, written by DON indicated waiting for OT orders for upper extremity evaluation and set up for functional maintenance program. Care plan with initiated date of 1/6/21, indicated R35 had a need for functional maintenance intervention to maintain strength and prevent falls. On 7/22/21, the care plan was revised to include: Active range of motion for ambulation every day PRN (as needed). Care conference note dated 8/5/21, written by (RN)-B indicated R35 remained on a functional rehabilitation program without concerns. R35's progress note dated 8/6/21, written by DON indicated skilled OT had made recommendations to update residents functional maintenance program which were to include exercises for upper extremity. Care plan with initiated date of 1/6/21, was revised on 8/6/21, to include: 1. Active range of motion: seated bilateral upper arm exercises with a dowel. 10 repetitions two times, PRN. 2. Active range of motion: NuStep (recumbent cross trainer equipment) for 5 minutes to promote ROM. Settings tolerated PRN. R35's progress note dated 8/17/21, by (RN)-I indicated OT completed an evaluation and would update R35's restorative program. During an interview on 8/23/21, at 2:41 p.m., R35 stated she used to get therapy and exercises for "frozen shoulders," but not anymore, adding she would like to have therapy again. R35 stated her shoulders were stiff and she couldn't do things for	2 895		

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2 895	Continued From page 8 herself without a lot of pain. During an interview on 8/25/21, at 7:49 a.m., nursing assistant (NA)-C stated she and (NA)-A provided restorative services to residents, but had not been providing services to R35 that she was aware of. NA-C stated she started the day caring for residents, then switched to restorative services at 10:00 a.m.; however was not always able to do that if needed on the floor. During an interview on 8/26/21, at 11:32 a.m., reviewed functional maintenance (the facility used this term rather than restorative services) form for R35 with the DON. The only date exercises had been done with R35 since the new order on 7/21/21, were on 8/8/21. The DON stated she would have expected it to have been more times; she expected it to be done daily, Monday through Friday unless a resident declined or refused, then she expected that to be documented. Informed there were no refusals documented for R35. When asked what PRN meant in relation to care plan interventions for R35, for example: Active range of motion: seated bilateral upper arm exercises with a towel. 10 repetitions two times, PRN, the DON stated it meant exercises where not scheduled on a specific day of the week for flexibility purposes, but she still expected them to be done daily Monday through Friday. The DON stated she did not know why R35's exercises had not been done - no one had informed her of this, and acknowledged physician orders needed to be carried out. The DON agreed that in this case, R35 needed exercises to maintain strength and prevent her shoulders from becoming stiff. The DON stated two NA's provided functional maintenance to residents and were available Monday through Friday. The DON admitted exercises might not get done if the NA's were not	2 895		

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2 895	Continued From page 9 able to switch from NA work to functional maintenance work, but that would not happen often. Facility policy titled "Restorative Functional Exercise" dated 4/6/21 included: Purpose: - to assess and instruct in endurance, strength, coordination, dexterity, activity tolerance, postural control, neck, trunk, upper and lower extremity range of motion and safety in all areas (all areas relate to ability/independence in activities of daily living) - to maintain muscle tone, strength and joint function - to prevent deformities caused by inactivity of a part - to help maintain normal physiologic function of all body systems - to increase strength, range of motion, coordination, activity tolerance and postural control for fall prevention, circulation and skin integrity. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to implementation of range of motion, could assure proper assessment and interventions are being implemented. The DON could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		

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2 965	Continued From page 10	2 965		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act when recommendations from the registered dietitian were identified but not implemented for 1 of 1 residents (R35) with weight gain. Findings include: R35's facesheet printed on 8/26/21, included diagnoses of major depressive disorder, dementia, anxiety and high blood pressure. R35's quarterly Minimum Data Set (MDS) assessment dated 7/23/21, indicated R35 was cognitively intact, had adequate hearing and vision, clear speech, was able to make self understood and could understand others. R35 required supervision of one eating, and had a weight gain of 5% or more in last month or 10% or more in last 6 months. R35's physician orders dated 6/26/21, included monitoring for side effects of antidepressant,	2 965	Correction Order #2965 Corrected Date: October 5, 2021 It is the current policy and procedure of GSS-Windom to monitor resident weights. R35 was re-assessed and their care plan updated regarding weight gain by the Dietician and Director of Food and Nutrition on Aug. 25, 2021. All residents are at potential risk for this deficient practice. A weight gain audit was conducted the Dietician and the Director of Nursing on Sept. 29, 2021, with the care plans of any additional residents with weight gain addressed. To prevent further potential deficient practice, the case managers will be re-educated and will complete a post-quiz on Oct. 5, 2021, by the Director of Nursing, regarding the monitoring of weights and appropriate follow-up per	10/5/21

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

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2 965	Continued From page 11 such as changes in weight and to monitor for effects of antipsychotic medication such as weight gain. R35's care plan with initiated date of 4/28/21, indicated R35 had an unplanned weight gain related to overeating, evidenced by weight gain; that R35 would express satisfaction with following the recommended portion size of snacks through the review date. Interventions included talking to R35 and her family about healthier snack options and portion size of snacks; coping behaviors, alternatives to over-eating, feelings related to food, adverse effects of weight gain. During an interview on 8/23/21, at 2:45 p.m., when asked if she had experienced weight loss or weight gain, R35 stated she had gained weight, but didn't know how much. When asked if she was concerned about that, she stated, "well, I don't want to gain anymore." R35's measured weights indicated a 12.41% weight gain in six months, from 145 pounds on 2/24/21, to 163 pounds on 8/23/21. Nutritional status progress note dated 4/25/21, and written by registered dietician (RD)-G, indicated R35 was on a regular diet, had no chewing or swallowing problems and was able to feed herself. R35's weight was 152 pounds, showing a gradual and persistent weight gain since admission in April 2020, and now a significant weight gain of 18 pounds (13.4%) in the past six months. R35's BMI was up to 31.8 (considered obese). MNA (mini nutritional assessment) score was 13, indicating normal nutritional assessment. The dietician note recommended talking to her family about her significant weight gain and recommended	2 965	GSS policy and procedure. An audit of weights in relation to weight gains and ensuring appropriate follow-up will be conducted by the QAPI Coordinator or designee will occur 1 time weekly for 12 weeks with the care planning schedule. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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2 965	Continued From page 12	2 965		

decreasing calorie intake, either by providing smaller portions in general, or by starting some specific lower calorie interventions. Interventions could include no bread at meals unless the menu is a sandwich, smaller portions of potatoes, smaller portions of desserts, lower calorie snack choices between meals and making sure to offer calorie free beverages between meals.

R35's diet card was reviewed. Serving size choices on the card were small, medium and large and medium was checked. No recommendations by the dietician from 4/25/21, were noted on the card.

During a telephone interview on 8/25/21, at 9:24 a.m., RD-G reviewed her care conference notes from April 2021, and stated "I supposed you're wondering if my recommendations were acted upon? I don't watch weight gains as closely. I give my recommends in writing to the DON and dietary. You should be able to look at those to see if they were followed through."

During an interview on 8/25/21, at 9:36 a.m., dietary supervisor (DS)-E located two sets of dietician notes dated 4/5/21, and 4/28/21, adding that RD-G reviewed resident nutrition status twice a month. The documents were titled Medical Records Reviewed by Consultant Dietician, and were in grid format with columns for residents name, nutrition problem, nutrition recommendation and follow-up columns for notification of all necessary staff. RD-G's recommendations were hand-written. R35 was not listed on either document. DS-E stated she was not aware of any recommendations for R35 from RD-G from April.

On 8/25/21, at 10:28 a.m. RD-G called back and

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2 965	Continued From page 13	2 965		

stated she had been working remotely in April so would have sent the director of nursing (DON) an email about R35's weight gain and recommendations.

During an interview 8/25/21, at 10:50 a.m., the DON did not recall receiving an email from RD-G regarding R35. The DON looked back in her emails and stated she did not have an email regarding R35 from the RD-G. The DON stated any recommendations by RD-G for R35 from 4/25/21, had not been communicated to dietary or nursing and therefore had not been implemented.

During an interview 8/25/21, at 10:56 a.m., DS-E stated she spoke to R35 and R35 stated she would like smaller portions and agreed she didn't want to gain any more weight, and would be okay trying smaller portions at meal times.

During an interview on 8/26/21, at 11:32 a.m., the DON had not been aware of R35's weight gain until 8/25, adding that RD-G's recommendations should have been followed through when R35's significant weight gain had been identified in April. The usual process for this was the dietician communicated recommendations in writing to dietary and to the DON in order for recommendations be carried out; e.g., added to the diet card and resident's care plan. The DON stated that process did not happen this time and could not explain why.

Facility policy titled Responsibilities of the Dietician - Food and Nutrition Services, dated 6/17/21, indicated the dietician reviewed all reports and resident records pertinent to the resident nutrition status, such as weight. The dietician provided written reports to the facility monthly regarding recommendations. The

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2 965	Continued From page 14 dietician reviewed recommendations with the DON at each visit. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or registered dietician could review and revise policies and procedures related to resident assessment, monitoring and implementation of dietary recommendations and educate staff. The DON or designee, could conduct audits to ensure compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental recommendations were acted upon and future appointments coordinated to ensure timely service for 1 of 1 residents (R30) reviewed for dental care.	21325	Correction Order #21325 Corrected Date: October 5, 2021 It is the current policy and procedure of GSS-Windom to follow-up on dental referrals in a timely manner.	10/5/21

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21325	Continued From page 15 Findings include: R30's facesheet printed 8/24/21, included diagnoses of Parkinson's Disease (progressive nervous system disorder that affects movement) and diabetes (metabolic disorder in which the body has high sugar levels for prolonged periods of time). R30's significant change Minimum Data Set (MDS) assessment dated 7/9/21, indicated R30 had moderate cognitive impairment, minimal difficulty hearing, adequate vision, clear speech, was able to make self understood and could understand others. The MDS further identified no dental problems, including broken or loosely fitting full or partial dentures (chipped, cracked, uncleanable or loose) or obvious or likely cavity or broken natural teeth. R30's plan of care intervention with revised date of 7/22/21, indicated R30 needed set up/supervision for oral care. Plan of care intervention with revised date of 8/10/21, indicated R30 used a divided plate and plastic silverware when eating. No mention of dental status. During an interview and observation on 8/23/21, at 4:14 p.m., R30 had missing and broken teeth on the bottom of his mouth and a full denture on the top. R30 stated, "I need a new set of dentures on top, they're chipped." R30 removed and displayed his full upper denture. Then added "they won't take me to the dentist," he had asked, but was told they were "full up." A clinic referral form dated 2/17/21, indicated R30 had attended a routine dental appointment that day. Progress notes hand-written by dental staff	21325	A dental appointment was re-scheduled for R30 on Sept. 21, 2021. All clients are at risk for this deficient practice. On Sept. 30, 2021, the Director of Nursing and Case Managers reviewed all client records for unmet dental referrals and no others were found. To prevent further potential deficient practice, the Case Managers will be re-educated and will complete a post-quiz by the Director of Nursing on Oct. 5, 2021, regarding appropriate and timely follow-up of dental appointments. An audit of dental referrals and appropriate follow-up will be conducted by the QAPI Coordinator or designee, 1x weekly for 12 weeks with the care planning schedule. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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21325	Continued From page 16	21325		

indicated R30 had had an initial exam, xrays and a filling. Notes indicated a referral was made to oral surgery for extraction of tooth #20; and following extraction, teeth would be added to his partial denture. Lastly, the facility was to call to make an appointment after the extraction.

R30's quarterly oral/dental assessment dated 4/6/21, indicated R30 had a partial lower bridge and full upper denture and had a pending [dental] appointment.

A copy of an electronic note dated 4/14/21, from oral surgery indicated R30 had an odentectomy (tooth removal) of tooth #20, and follow up instructions included to continue local dentist follow-up.

R30's care conference note dated 4/29/2021, at 10:37 a.m. indicated attendance by R30's daughter (via phone), registered nurse (RN)-A, recreation/wellness (RW)-A, licensed social worker (LSW)-A. R30 declined to attend. Care conference note indicated R30 saw the dentist a couple weeks ago and had teeth extracted. R30 was in need of a new denture plate as his denture plate went missing some time ago. R30's daughter was not concerned since R30 would likely be getting a new plate anyway since teeth were extracted.

R30's annual oral/dental assessment dated 7/6/21, indicated R30 had a partial upper bridge and a partial lower bridge and had a pending appointment for follow-up dental work.

During an interview on 8/24/21, at 2:28 p.m., administrative receptionist (AR)-F who made appointments for residents was asked if R30 had a dental appointment scheduled. AR-F looked in

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21325	Continued From page 17 a folder and stated no, he did not have a dental appointment scheduled. AR-F presented a form titled: Appointment and Ride Request Intake, completed by RN-A which indicated resident and daughter requested a dental appointment as soon as possible. The form was not dated. There was a hand-written notation in pencil: "Eyes 1st Aug 4th." AR-F stated R30 wanted to wait till until after his eye appointment on 8/4/21, to go to the dentist, but then R30 canceled his eye appointment. AR-F stated after the eye appointment had been canceled on 8/4, the dental appointment had not been scheduled. AR-F had not been aware that R30's 2/17/21, dental instructions indicated the facility was to make another appointment after his tooth was extracted, and his tooth was extracted on 4/14/21. During an interview on 8/26/21, at 10:58 a.m., the DON stated she had not been aware of the sequence of events that occurred with R30's dental appointments until this day, but was aware AR-F had just made a dental appointment for R30. "It seems it should have been made sooner." When asked who reviewed dental notes to act upon follow-up instructions by the dentist, the DON stated nurses would do that and let AR-F know to make the appointment. DON was not sure what happened this time that the ball was dropped. The DON stated RN-A, who completed the Appointment and Ride Request Intake form had not worked since early July 2021, so the form which indicated R30 and his daughter had requested a dental appointment as soon as possible, would have been filled out in early July or earlier than that. The DON confirmed the appointment should have been made sooner, following the dentist's instructions.	21325		

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21325	Continued From page 18 No facility policy was provided on making appointments for residents. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure dental care services and follow up dental care is provided to all residents in accordance with individual needs. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing measures to prevent the spread of COVID-19 when the facility failed to ensure personal protective equipment (PPE) including mask worn correctly, and when the facility failed to separate an unvaccinated resident from vaccinated residents at meal time. This had	21375	Correction Order #21375 Corrected Date: October 8, 2021 On Aug. 24, 2021, R46 was placed at a personal table, 6 feet away from other residents, but facing them. This arrangement continues. Staff on duty at the time of the incident were immediately re-educated by the Activity Director and the Director of Nursing.	10/8/21

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21375	Continued From page 19 the potential to affect all 60 residents who resided in the facility. Findings include: Unvaccinated Resident During entrance conference on 8/23/21, at 1:55 p.m., was informed that one resident in the facility, R46, was not vaccinated for Covid-19. During an observation on 8/23/21, at 5:57 p.m., R46 was observed eating at a small square table, approximately 4 feet by 4 feet, in the nurses station dining room. At the table with R46 was R25 and R30. None of the residents were masked. During an interview and observation on 8/24/21, at 8:50 a.m., observed R46, the facility's only unvaccinated resident, eating at a small, square table in the nurses station dining room with two other residents, R25 and R30. Licensed practice nurse (LPN)-B stated she did not know if there were any unvaccinated residents in the facility; she would have to call the front desk to find out. LPN-B was not sure if vaccinated and unvaccinated residents could eat together at the same table and would have to ask the DON. During an interview on 8/24/21, at 8:52 a.m. (RN)-I stated there was only one resident on the north side who had not been vaccinated for Covid-19 and that was R46. RN-I confirmed R46 was eating breakfast at a table in the nurses station dining room with R25 and R30. When asked if it was okay for an unvaccinated resident to eat in close proximity to other residents, RN-I stated, "I don't know.....that's what we've always done."	21375	No other residents at the time of survey were unvaccinated. One short-term client is currently unvaccinated and their dining situation follows appropriate guidelines. All staff present on Aug. 23, 2021, were immediately re-educated regarding proper mask use and were provided with a different style mask if needed to ensure proper fit. Any new unvaccinated residents would be at risk for this deficient practice. All clients upon admission are assessed for vaccination status and will dine in accordance with GSS policy and procedure aligning with current state and federal guidelines. All residents would be at risk for staff not wearing/using masks appropriately. A Root Cause Analysis was conducted on Sept. 22, 2021, by the QAPI committee, including the Infection Preventionist and was reviewed and approved by the Good Samaritan Society Nursing and Clinical Services Consultant and the Good Samaritan Society Quality Improvement Advisor. All policies and procedures for PPE usage during the COVID-19 pandemic, including source control masks, proper use of gowns, and transmission-based precautions, were reviewed and found to be appropriate. To prevent further potential deficient practice of unvaccinated resident dining, all staff were re-educated Oct. 4-8, 2021, through learning boards and a post-quiz	

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21375	Continued From page 20 During an interview on 8/24/21, at 11:37 a.m., the DON was asked where the unvaccinated resident, R46, ate her meals. The DON stated she was aware of CDC guidance that unvaccinated residents should be six feet away from vaccinated residents when eating. The DON stated R46 was in a pattern of coming out of her room and going to that table. "It would be hard to accommodate...need to look at the bigger picture...likes to eat at the table and she doesn't stay long." The DON stated she would talk to her team about other options. During an observation on 8/24/21, at 12:54 p.m., observed R46 eating at a table by herself in the nurses station dining room, at least six feet away from a table with R25 and R30. Another table had been set up for R46, and the table had a placard with her name on it in the center of the table. R46 was not isolated and was still able to see and hear other residents and staff. Facility policy titled Covid 19 Guidance: Long-term Care Indoor Visitation for Nursing facilities and Assisted Living-type settings from the State department of health, dated 5/20/21, indicated if unvaccinated residents are present during communal dining or activities, then all residents should use face coverings when not eating, and unvaccinated residents should physically distance from others Mask Observations On 8/23/21, the following mask observations were made: of staff and visitors in the facility who were not appropriately wearing face masks. At 1:42 p.m., administrative receptionist (AR)-F was observed with mask below nose.	21375	developed by the Administrator, Director of Nursing, and a Case Manager, regarding the current requirements for unvaccinated resident dining. To prevent further potential deficient practice of mask wearing, all employees were re-educated through lecture, demonstration, and competency testing, by the Clinical Learning and Development Specialist on Sept. 28-30, 2021, regarding standard infection control practices, including transmission-based precautions, appropriate PPE use, and donning and doffing PPE. Residents and their representatives will be educated via email/postal mail/room delivery on Oct. 1, 2021, and in person on Oct. 6, 2021, at the Resident Council by the Administrator and Infection Preventionist regarding the facility infection control program, including visitor responsibilities. Any unvaccinated resident dining situations will be randomly audited by the QAPI Coordinator or designee, 3 times per week at various meals for 4 weeks, then 1 time per week for 8 weeks. The QAPI Coordinator and designees will audit in the following manner. A minimum of 10 times per week for 4 weeks, then 5 times per week for 8 weeks or until compliance is sustained; covering multiple shifts and multiple departments. People audited will include, employees, visitors, and residents. Items to be audited include, but are not limited to: donning and doffing of PPE with transmission-based precautions, aerosolized generating procedures to	

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21375	Continued From page 21 At 1:38 p.m., the director of nursing (DON) was observed with mask below nose. At 2:31 p.m., nursing assistant (NA)-D was observed with mask below nose. At 3:19 p.m., DON was observed to continue to wear mask below nose. At 3:30 p.m., registered nurse (RN)-J was observed with mask below nose. At 3:30 p.m., maintenance (M)-A was observed with mask below nose. At 5:45 p.m., (NA)-E was observed with mask below nose. At 5:50 p.m., While in R47's room, observed activities (A)-B bend forward at the waist, directly in front of R47 in his wheelchair, about one foot from his unmasked face and pull down her mask below her chin to talk to him about supper. At 6:11 p.m., observed a female visitor of a resident in the dining room on the 500 wing, feeding him, wearing mask below her nose. At 6:27 p.m., observed NA-E in the dining room of the 500 wing assisting a resident to eat. Mask was below chin. When saw surveyor, pulled mask up to below nose. During an interview on 8/23/21, at 6:40 p.m.., the director of nursing (DON) and administrator were asked what the expectation was for staff wearing masks, was it okay for them to be worn below the nose. The DON stated no, it was not acceptable -- it was not the correct way to wear a mask for infection control purposes. The DON stated masks did not stay up on her face, as she manipulated it while talking. The administrator stated they would look into it. During an observation on 8/23/21, at 7:01 p.m., observed DON with a different style surgical mask on. The mask was observed to be yellow, not blue. The DON stated they found some	21375	ensure PPE is used, and proper use of PPE gowns. All audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21375	Continued From page 22 additional masks and these were better fitting for her. The mask was observed to be worn properly. During an observation on 8/23/21, at 7:10 p.m., observed the DON handing out masks to some staff and speaking to them about wearing masks properly. Facility policy titled Covid-19 Guidance: Long-term Care Indoor Visitation for Nursing facilities and Assisted Living-type settings from the State department of health, dated 5/20/21, indicated staff were to wear a well-fitting facemask that fully covers the mouth and noise, in accordance with CDC guidance. residents should physically distance from others. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could monitor to assure proper PPE is worn to prevent the potential spread of infections. The DON or designee could monitor to ensure staff are wearing appropriate PPE during care and as recommended by CMS, CDC and State Agency to prevent the spread of COVID-19. The DON or designee could educate staff and perform audits to ensure the policies are being followed. The results of these audits could be reviewed by the quality assurance committee to ensure compliance. Time Period for Correction: Twenty-one (21) days.	21375		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with	21805		10/8/21

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	00085	A. BUILDING: _____ B. WING _____	C 08/26/2021

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21805	Continued From page 23 courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 1 residents (R29) who were required assistance with activities of daily living (ADLs). Findings include: R29's facesheet printed 8/25/21, indicated R29 was admitted to the facility 1/4/21, and diagnoses included glaucoma, abnormalities of gait and mobility, and pain in left hip. R29's quarterly Minimum Data Set (MDS) assessment dated 7/9/21, identified R29 was cognitively intact and required two person physical assist with dressing, toilet use, personal hygiene, bathing, and utilized a wheelchair for mobility. R29's care plan dated 1/4/21, indicated an ADL self care performance deficit R/T [related to] weakness and inability to independently dress, groom, toilet and bathe self and interventions included dressing with total assist of 1-2 with lower body, encourage participation with upper; toilet use total lift, large sling and 2 assist to transfer on/off commode/toilet and total assist with clothing management and hygiene. On 8/23/21, at 3:40 p.m. R29 was observed and interviewed while seated in a wheelchair in his room. R29's pants were observed poor fitting,	21805	Correction Order #21805 Corrected Date: October 8, 2021 It is the current policy and procedure of GSS-Windom to provide care consistent with resident dignity. R29: The pants were changed and removed on Aug. 25, 2021. Available employees were re-educated immediately. All residents are at risk for this deficient practice. An audit was conducted by a Case Manager on Oct. 1, 2021 of resident clothing and any additional clothing that did not fit properly was removed. To prevent further potential deficient practice, all nursing staff were re-educated Oct. 4-8, 2021, through learning boards and a post-quiz developed by the Administrator, Director of Nursing, and a Case Manager regarding the resident's right to dignity, especially in regard to proper fitting clothing. At the Oct. 6 resident council meeting, the administrator will review the right to dignity with the residents. A random audit of residents regarding proper fitting clothing will be conducted by the QAPI Coordinator or designee, 3 times weekly for 4 weeks and then 1 time per week for 8 weeks. Audit results will be	

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21805	Continued From page 24 baggy, with snaps at each side not buttoned, or pulled up around R29's waist. R29 stated "my pants are embarrassing" and further indicated he went to breakfast, noon meal, and bingo dressed as he was. R29 stated could fit "two elephants" in his pants . R29 indicated he wanted to get rid of the pants he had on, and stated he didn't get to choose his pants, and stated he would never want to wear these [pants]. R29 further indicated he "dreads" when staff take out the pants. On 8/263/21, at 3:46 p.m. licensed practical nurse (LPN)-A stated R29 had adaptive pants, and confirmed the pants were extremely large for the resident and should be buttoned at the sides of the waist. LPN further stated he had other adaptive pants that fit appropriately to wear. On 8/25/21, at 7:37 a.m. nursing assistant (NA)-A stated R29's adaptive pants were too big and were exchanged for smaller pants. On 8/25/21, at 7:41 a.m. the director nursed (DON) stated when residents utilized a lift (mechanical devise used to assist with transfer) adaptive pants were used and social services arranged with the family the correct size and style. The DON stated R29 should not have been dressed with extremely baggy pants and expected the pants to be fastened. On 8/25/21, at 7:42 a.m. an interview with registered nurse (RN)-J stated the pants R29 wore on 8/23/21 were his personal adaptive pants. RN-J confirmed the pants were too large and were given to social services to take out the residents clothing choices. RN-J stated staff were expected to dress residents with well fitted clothing and appearance was important to R29.	21805	reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

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21805	Continued From page 25 Policy titled Activities of Daily living rehab/skilled dated 12/28/28, indicated -Purpose: To provide residents with appropriate treatment and services to maintain or improve abilities in activities of daily living for the well being of mind, body and soul. - Policy any resident who is unable to carry out activities of daily living or receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. - Dressing: selecting, obtaining and putting on, fastening and taking off items of clothing including braces and prosthesis. - Toileting: transferring on and off the toilet, use of bedpan, urinal or commode; cleansing after elimination; changing any protective pads; adjusting clothing after toileting. Policy titled Resident dignity rehab/skilled dated 10/6/20, indicated -To maintain the dignity of all residents -To promote encourage support enhance the residents self esteem -To promote a sense of self worth -To assist with respecting and abiding their residents rights Policy: -The location will promote care for residents and a manner in an environment that maintains or enhances each residence dignity and respect in full recognition of his or her individuality. -Encouraging and assisting resident to dress in their own Clothes appropriate to the time of day and individual preference is, rather than hospital type gowns. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure	21805		

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21805	Continued From page 26 residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits could be reviewed by the quality assurance committee to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the 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 and document review the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 60 resident families who reside in the facility. Findings include: During interview on 8/26/21, at 8:52 a.m. social service designee (SSD) confirmed the facility did	21915	Correction Order #21915 Corrected Date: Sept. 21, 2021 Family Council An email/postal mail communication was sent to families/responsible parties on Sept. 21, 2021 regarding family council and the opportunity to form said council. If a family council is not formed at this time, the QAPI Coordinator will audit in	9/21/21

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21915	Continued From page 27 not have an existing family council. The SSD further confirmed no attempt had been made to form a family council since 6/12/2019. During interview on 8/26/21 at 11:30 a.m., the administrator (ADM) confirmed no attempt had been made to form a family council since 6/12/2019 and indicated due to Covid-19, they would not have been able to form a family council due to visitor constraints. The ADM however indicated there were alternatives to onsite meetings. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure thorough attempts are made to develop a family council. The administrator or designee could develop monitoring systems to ensure thorough attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915	September, 2022 to assure the facility offers the opportunity to form said council.	