CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

			ION AND TRANSMITTAL STATE SURVEY AGENCY	ID: PELM Facility ID: 00085
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245558 2.STATE VENDOR OR MEDICAID NO. (L2) 677840200	3. NAME AND ADD: (L3) GOOD SAMA! (L4) 705 SIXTH ST (L5) WINDOM, MN	RITAN SOCIETY REET	7 - WINDOM (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
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 10/28/2021 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TIC 2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): To (b):	7. PROVIDER/SUPP 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF 10.THE FACILITY IS X A. In Compliance Program Rec Compliance	05 HHA	ICE/IID 15 ASC RHC 16 HOSPICE	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31 The Following Requirements: 6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 72 (L18) 13.Total Certified Beds 72 (L17)	B. Not in Comp	ceptable POC liance with Program d/or Applied Waivers:	4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A*	_
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 72 (L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABL	ICF (L42) E SHOW LTC CANCEL	IID (L43) LATION DATE):	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE Elizabeth Silkey, Unit Supervisor	Date : 11/	/30/2021	18. STATE SURVEY AGENCY Melissa Poepping, Ent	
PART II - TO BE	COMPLETED B	`	ONAL OFFICE OR SINGLE ST	,
19. DETERMINATION OF ELIGIBILITY		LIANCE WITH CIVII ITS ACT:		ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) /e:
	OF PARTICIPATION BEGINNING DATE ENDIN			05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTERNATIV	of Admissions:	(L44) (L45)	03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: 29	INTERMEDIARY/CA		30. REMARKS	
(L28)	00140		.31)	

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

11/01/2021

(L32)

31. RO RECEIPT OF CMS-1539



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

Mighan

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered 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

Missing

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	_
PART L. TO BE COMPLETED BY THE STATE SURVEY ACENC	v

Facility ID: 00085

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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: 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

Good Samaritan Society - Windom September 21, 2021 Page 2 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

Good Samaritan Society - Windom September 21, 2021 Page 3

(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

Good Samaritan Society - Windom September 21, 2021 Page 4

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

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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

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245558	B. WING			08/	26/2021	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		70	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH STREET VINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMEN	TS	K 0	000				
	conducted by the M Public Safety, State 08/26/2021. At the SAMARITAN SOCI not in compliance v participation in Med Subpart 483.70(a), 2012 edition of Nat Association (NFPA Chapter 19 Existing edition of NFPA 99,	ety Code survey was dinnesota Department of e Fire Marshal Division on time of this survey, GOOD ETY - WINDOM was found with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection 101, Life Safety Code (LSC), g Health Care and the 2012 Health Care Facilities Code. OC WILL SERVE AS YOUR COMPLIANCE UPON THE						
LABORATOR `	DEPARTMENT'S ASIGNATURE AT THE PAGE OF THE CMUSED AS VERIFICATION ON SITE REVISIT OF CONDUCTED TO SUBSTANTIAL COREGULATIONS HAS ACCORDANCE WAS PLEASE RETURN CORRECTION FOR DEFICIENCIES (KAIF PARTICIPATING PAPER COPY OF IS NOT REQUIRED	ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE PATION OF COMPLIANCE. OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY -TAGS) TO: G IN THE E-POC PROCESS, A THE PLAN OF CORRECTION	NATURE		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245558 B. WING 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **705 SIXTH STREET GOOD SAMARITAN SOCIETY - WINDOM WINDOM, MN 56101** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 000 | Continued From page 1 K 000 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GOOD SAMARITAN SOCIETY - 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

CLIVILI	13 I OIT WEDICARE	& MEDICAID SERVICES			OND NO	<u>. 0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	I \ '	E SURVEY IPLETED
		245558	B. WING		08/	26/2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP 705 SIXTH STREET WINDOM, MN 56101	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 000	Standard 101, Life 19 Existing Health The facility is fully pautomatic sprinkler system with smoke spaces open to the automatic fire department of the facility has a consus of 60 at the	ction Association (NFPA) Safety Code (LSC), Chapter Care Occupancies. protected throughout by an a system and has a fire alarm a detection in the corridors, a corridors that is monitored for	К0	00		
K 271 SS=F	Discharge from Ex Exit discharge is an provides a level was provisions of 7.1.7 elevation and shall obstructions. Addit be a hard packed a 18.2.7, 19.2.7 This REQUIREME by: Based on observation facility failed to main accordance with N Safety Code, section the section of the	its	K 2	K-271 Corrected Date: Sept. 30, 2 The exits for the Southwes Northeast Dining Room do door, and Southeast door von Sept. 23, 2021 by the M	et door, 2 ors, Northwest were repaired	9/30/21
	Findings include:			Director to assure a smoot Annual Door inspections, v	h exit path.	

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245558	B. WING			08/2	26/2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		7	STREET ADDRESS, CITY, STATE, ZIP CODE 105 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, inspendintal particles and protection Systems maintained in a secondary and provided and p	ndard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily system last checked system test supply source KS information on coverage for or partial automatic sprinkler	K3	353	K-353 Corrected Date: Oct. 8, 2021 The sprinkler head obstructions in storage closet, rooms 408, 219, 20 and the corridor closet adjacent to 403, were corrected on Aug. 26, 20 The sprinkler heads with oxidation paint were replaced by Building Spilnc. on Sept. 28, 2021. All additional sprinkler heads were for obstructions, oxidation, and pain the Maintenance Director on Sept. 2021. Any needed storage correcti were made immediately. Three ad potential oxidation issues were ider and replace on Sept. 28, 2021. Tape/signs, to indicate storage heiglimits, were placed by maintenance	OG, room D21. and rinkler audited at by 27, ions ditional atified	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245558 B. WING 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **705 SIXTH STREET GOOD SAMARITAN SOCIETY - WINDOM WINDOM, MN 56101** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) K 511 | Continued From page 9 K 511 K 511 Utilities - Gas and Electric K 511 9/30/21 SS=F 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 Based on observation and staff interview, the K-511 facility failed to maintain security to electrical Corrected Date: Sept. 30, 2021 panels in a resident accessible corridor in accordance with NFPA 101 (2012 edition). Life Locks were added to the electric panels Safety Code, sections 19.5.1.1 and 9.1.2, NFPA on the 400 wing, Southwest corridor, and 70 (2011 edition), National Electrical Code, west corridor by the Maintenance Director section 110.26, and NFPA 99, (2012 edition), on Sept. 10, 2021. All other panels had Health Care Facilities Code, section 6.3.2.2.1.3. locks when inspected on Aug. 26, 2021. These deficient conditions could have a widespread impact on the residents within the Maintenance employees were educated facility. by the Maintenance Director and Administrator on Sept. 30, 2021, regarding electric panel locking Findings include: requirements. On 08/26/2021 between 11:00 AM to 4:00 PM, it was revealed during the walk-thru of the facility This issue was reported to the Safety and that the following electrical panels in resident QAPI Committees on Sept. 29, 2021, for accessible corridors were unsecured: follow-up. 1. 400 Wing 2. Southwest corridor 3. West corridor

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245558 B. WING 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **705 SIXTH STREET GOOD SAMARITAN SOCIETY - WINDOM** WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) K 511 | Continued From page 10 K 511 These deficient conditions were confirmed by the Maintenance Director. K 761 Maintenance, Inspection & Testing - Doors K 761 9/30/21 SS=F 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 Based on observation, review of available K-761 documentation, and staff interview, the facility Corrected Date: Sept. 30, 2021 failed to inspect and maintain door assemblies per NFPA 101 (2012 edition), Life Safety Code, The dining room door exit was fixed on sections 19.7.3.1, 19.7.6, 4.6.12, 7.2.1.7, Sept. 15, 2021, by the Maintenance 7.2.1.4.5.1 and NFPA 80 (2010 edition), sections Director. All other doors were inspected 5.2.1, 6.1, 6.1.4.2 This deficient condition could for the same issue on Aug. 26, 2021 and have a widespread impact on the residents within were found to be in compliance. the facility. Annual door inspections were started on Sept. 1, 2021, by the Maintenance Findings include: Director. 1. On 08/26/2021 between 11:00 AM to 4:00 PM, Maintenance employees were educated it was revealed that upon testing the Dining Room by the Maintenance Director and exit door, it required greater than 30 pounds of Administrator on Sept. 30, 2021, force to open the door. regarding annual door inspections and

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	ND DLAN OF CODDECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245558	B. WING _		08/	26/2021	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 914	This REQUIREMEI by: Based on a review and staff interview, receptacle testing i (2012 edition), Heasection(s) 6.3.3.2. have a widespread the facility. Findings include: On 08/26/2021 betwas revealed during no documentation electrical outlet testoccurred since 201	NT is not met as evidenced of available documentation the facility failed to complete no resident rooms per NFPA 99 alth Care Facilities Code, This deficient condition could impact on the residents within ween 11:00 AM to 4:00 PM, it godocumentation review that was presented to confirm that ting of the resident rooms had 6.	K 91	K-914 Corrected Date: Sept. 30, 2021 Annual testing was initiated on 2021 by the Maintenance Direct electric receptacles were tested resident rooms Sept. 21-25, 20 Maintenance Director. Any corwere completed and verified im Maintenance employees were by the Maintenance Director an Administrator on Sept. 30, 2027 regarding annual electric receptinspections and how to follow-ut. The annual electric receptacle have been added to the TELS preventative maintenance systeproduces a weekly report of tascompleted. The 2021 annual ereceptacle inspections that were completed Sept. 21-25, 2021, verviewed at the Sept. 29, 2021 Committee meeting for compliatissue was reported to the QAPI Committee on Sept. 29, 2021, 1 follow-up.	Sept. 1, tor. All d in 21 by the rections mediately. educated d 1, tacle p. inspections em, which sks not lectric e vere Safety ance. This		
K 920 SS=E		nt - Power Cords and Extens	K 92	•		10/8/21	
	Extension Cords Power strips in a paused for componer	nt - Power Cords and atient care vicinity are only nts of movable d electrical equipment					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245558	B. WING	;		08/2	26/2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		7	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 920	(PCREE) assemble by qualified person 10.2.3.6. Power str may not be used for electronics), except rooms that do not used for electronics, except rooms that do not used for electronics, except rooms that do not used for electronics. Extensing for non-PCRI (outside of vicinity) care rooms, power standards. All power standards. All power standards. Extension cords used immediately upon of which it was installed 10.2.4. 10.2.3.6 (NFPA 99) (NFPA 70), 590.3 (Extension condition), 590.3 (Extension condition), Health Carlonical facility failed to propower strips in acceedition), Health Carlonical Electrical (590.3 (D). These depatterned impact of facility. Findings include: 1. On 08/26/2021 bit was revealed durfacility that multi-taluse in the Training	es that have been assembled nel and meet the conditions of rips in the patient care vicinity or non-PCREE (e.g., personal tin long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL er strips are used with general usion cords are not used as a wiring of a structure. ed temporarily are removed completion of the purpose for ed and meets the conditions of the notation and staff interview, the perly implement the usage of ordance with NFPA 99 (2012 ore Facilities Code, section d NFPA 70, (2011 edition), Code, sections 400-8, efficient conditions could have a notation the perly implement within the netween 11:00 AM to 4:00 PM, ing facility walk-thru of the pelectrical adapters were in	K	9920	K-920 Corrected Date: Oct. 8, 2021 The multi-tap adapter in the training was replaced on Sept. 8, 2021, by t Maintenance Director. The room 1 extension cord that was connected power strip was removed on Aug. 2 2021 by the Maintenance Director. rooms were inspected on Sept. 21, for extension cords and multi-tap cowith any extension cords or multi-taissues corrected immediately. Maintenance employees were educ on Sept. 30, 2021, by the Maintena Director and Administrator regardin of extension cords/multi-taps. They	the 07A to a 66, All 2021 ords ap cated nce g use	

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	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245558	B. WING		08/2	26/ 2021
	PROVIDER OR SUPPLIER	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101	1 00/2	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
	Appendix Z, Emerg Requirements, §48	1, a survey for compliance with ency Preparedness 3.73(b)(6) was conducted ecertification survey. The bliance.				
F 000	signature is not req page of the CMS-29 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents.	F 000			
	survey was conductinvestigation was all was found to be NC requirements of 42	1, a standard recertification ted at your facility. A complaint lso conducted. Your facility OT in compliance with the CFR 483, Subpart B, ong Term Care Facilities.				
	UNSUBSTANTIATE	laint were found to be ED: H5558028C 558027C (MN00058952)				
	as your allegation of Departments acception enrolled in ePOC, yat the bottom of the	f correction (POC) will serve of compliance upon the stance. Because you are your signature is not required of first page of the CMS-2567 ic submission of the POC will cion of compliance.				
F 550	onsite revisit of you		F 550			10/8/21
	<u> </u>	DER/SUPPLIER REPRESENTATIVE'S SIGN		' TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
		245558	B. WING _			C / 26/2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP COE 705 SIXTH STREET WINDOM, MN 56101	•	,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550 SS=D	self-determination, access to persons a outside the facility, this section. §483.10(a)(1) A fact with respect and digresident in a manner promotes maintenather quality of life, reindividuality. The fapromote the rights of \$483.10(a)(2) The faccess to quality caseverity of condition must establish and practices regarding provision of service residents regardles. §483.10(b) Exercise The resident has the rights as a resident or resident of the U \$483.10(b)(1) The face interference, coercification of the facility.	and transfer, discharge, and the regardless of diagnosis, n, or payment source. A facility must provide equal transfer, discharge, and the sunder the State plan for all so f payment source. Be of Rights. Be of Rights. Be cility must ensure that the se his or her rights without on, discrimination, or reprisal	F 55			
	free of interference	, coercion, discrimination, and cility in exercising his or her				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		245558	B. WING		C 08/26/2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101	00/10/101
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 550	rights and to be supexercise of his or his or his part. This REQUIREMED by: Based on observareview, the facility final maintained for 1 of required assistance (ADLs). Findings include: R29's facesheet primas admitted to the included glaucoma mobility, and pain in R29's quarterly Minassessment dated cognitively intact arphysical assist with hygiene, bathing, a mobility. R29's care plan dasself care performar weakness and inable groom, toilet and be included dressing wellower body, encour	ported by the facility in the er rights as required under this NT is not met as evidenced tion, interview and document ailed to ensure dignity was 1 resident (R29) who were with activities of daily living inted 8/25/21, indicated R29 a facility 1/4/21, and diagnoses, abnormalities of gait and	F 550	F-550 Correction Order #21805 Corrected Date: October 8, 2021 It is the current policy and procedure GSS-Windom to provide care consist with resident dignity. R29: The pants were changed and removed on Aug. 25, 2021. Available employees were re-educated immed All residents are at risk for this defici practice. An audit was conducted by Case Manager on Oct. 1, 2021 of reclothing and any additional clothing the 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 sright to dig especially in regard to proper fitting clothing. At the Oct. 6 resident council meeting	e diately. Sent y a sident chat chat chat chat chat chat chat cha
	On 8/23/21, at 3:40 interviewed while s room. R29's pants	mode/toilet and total assist gement and hygiene. p.m. R29 was observed and eated in a wheelchair in his were observed poor fitting, at each side not buttoned, or		administrator will review the right to with the residents. A random audit of residents regarding proper fitting clothing will be conducted the QAPI Coordinator or designee, 3 times weekly for 4 weeks and then 1	ng led by

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION	СОМ	E SURVEY PLETED	
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP COI 705 SIXTH STREET WINDOM, MN 56101	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	pants are embarras went to breakfast, ras he was. R29 sta his pants. R29 ind the pants he had or choose his pants, a want to wear these he "dreads" when so the waist. LPN furt adaptive pants that the waist. LPN furt adaptive pants were exchanged for the waist. LPN furt adaptive pants were arranged with the fastyle. The DON stated when the waist with extreme the pants that the waist of the pants on 8/25/21, at 7:42 registered nurse (R wore on 8/23/21 we pants. RN-J confirm and were given to se residents clothing the expected to dress residents clothing the pants.	29's waist. R29 stated "my sing" and further indicated he noon meal, and bingo dressed ated could fit "two elephants" in icated he wanted to get rid of n, and stated he would never [pants]. R29 further indicated taff take out the pants. 6 p.m. licensed practical nurse had adaptive pants, and swere extremely large for the be buttoned at the sides of her stated he had other fit appropriately to wear. a.m. nursing assistant (NA)-A ve pants were too big and residents utilized a lift used to assist with transfer) er used and social services amily the correct size and ated R29 should not have been nely baggy pants and	F 55	per week for 8 weeks. Audit r reviewed by the QAPI commi appropriate follow-up initiated solutions are sustained.	ttee with	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245558	B. WING			C 26/2021
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101	1 00/	20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
	Policy titled Activities dated 12/28/28, ind -Purpose: To provice treatment and service abilities in activities being of mind, body - Policy any resident activities of daily lives services to maintain personal and oral hard - Dressing: selecting fastening and taking including braces and - Toileting: transferr of bedpan, urinal or elimination; changing adjusting clothing and policy titled Resided 10/6/20, indicated -To maintain the digustriant the digustriant to promote a sension of the selection of the selection of the selection of his encouraging and a their own Clothes a and individual prefet type gowns. Increase/Prevent Directivities and individual prefet type gowns. Increase/Prevent Directivities and individual prefet type gowns.	es of Daily living rehab/skilled icated le residents with appropriate ces to maintain or improve of daily living for the well and soul. It who is unable to carry out ing or receive necessary in good nutrition, grooming and ygiene. If you want to go of thems of clothing deprosthesis. In go on and off the toilet, use commode; cleansing after ing any protective pads; fiter toileting. In the dignity rehab/skilled dated anity of all residents rage support enhance the improve of self worth ecting and abiding their comote care for residents and ironment that maintains or idence dignity and respect in sor her individuality. It is sisting resident to dress in perpopriate to the time of day irence is, rather than hospital ecrease in ROM/Mobility	F 5			10/8/21
SS=D	CFR(s): 483.25(c)(1)-(3)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		LOCATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245558	B. WING			08/2	26/2021	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM				STREET ADDRESS, CITY, S 705 SIXTH STREET WINDOM, MN 56101	STATE, ZIP CODE	33.2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD I DED TO THE APPROPR EFICIENCY)	BE	(X5) COMPLETION DATE	
F 688	§483.25(c) Mobility §483.25(c)(1) The resident who enter range of motion do range of motion un condition demonst of motion is unavoid §483.25(c)(2) A resmotion receives apprevent further deceives apprevent further deceives appropria assistance to main the maximum practeduction in mobility This REQUIREME by: Based on observative the facility function program for implemented for 2 reviewed who had Findings include: R4's face sheet, prodiagnoses of hemicological cerebrovascular (control to the brain) disease non-dominant side R4's annual Minimal assessment dated intact cognition, limupper and lower expenses the state of	facility must ensure that a sethe facility without limited es not experience reduction in less the resident's clinical rates that a reduction in range dable; and sident with limited range of expropriate treatment and erange of motion and/or to crease in range of motion. Sident with limited mobility the services, equipment, and tain or improve mobility with ticable independence unless a y is demonstrably unavoidable. NT is not met as evidenced tion, interview and document ailed to ensure a range of a rupper extremities was of 2 residents (R4, R35) limited range of motion.	F 6	F-688 Correction Order # Corrected Date: O It is the current po GSS-Windom to p to residents. On Aug. 30, 2021, therapy, who asse splint on Aug. 30, and treatment recorded the new spl For R35, on Sept. maintenance prog reflect current nee program was atter poor outcomes. Fig. 10 pp. 10 p	october 8, 2021 licy and procedure brovide ROM as not provide ROM as	to a slan to ctional to with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245558	B. WING		C 08/26/2021		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/20/2021	\dashv	
				705 SIXTH STREET			
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101			
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F 688	transfers, bed mob assist of one for pe	ility and toileting and extensive rsonal hygiene.	F 688	back to therapy on Sept. 30, 2021 further assessment.			
	7/22/21, indicated I maintenance progr physical mobility re needing assistance ambulation. Intervo of motion to include train exercise mach ambulate with 1 as distance R4 can to	entions included active range e NuStep (recumbent cross nine) two times per week and sist and wheelchair to follow at lerate as needed. There was dressing passive ROM or R4's		All clients at risk for contractures we evaluated for additional service need Appropriate care plan updates were completed by the Case Managers Service. 1, for anyone found to be a All clients on functional maintenance services are at risk for this deficient practice. All functional maintenance programs were assessed and updated Sept. 29-Oct. 1, 2021 by the Director of Nursing and the Case Managers.	eds. e Sept. t risk. e t t		
	3:16 p.m., R4 was hand lying on her la and 5th finger bent but not touching. Use move her left finger assistance from he do not do any ROM does she have a spleg works better that having therapy for finished physical the walking. During observation a.m., R4's left thum bent in towards the indicated she does	and interview on 8/23/21, at sitting in a recliner with left ap, with thumb, middle finger towards the palm of the hand Jpon request R4 was unable to rs, hand or arm without r right hand. R4 indicated they on her left hand or fingers nor plint. R4 further stated her left an her arm and does not recall her upper extremity, but just erapy for transfers and and interview on 8/25/21, 7:34 ab, middle, and 5th finger were palm of her hand. R4 not recall therapy ever and since she has been at this		To prevent further potential deficier practice, all nursing staff were re-educated Oct. 4-8, 2021, throug learning boards and a post-quiz developed by the Administrator, Dir of Nursing, and a Case Manager, regarding the importance of comple ROM programs and contractures. The case managers will be re-educand will complete a post-quiz on Oc 2021, by the Director of Nursing, regarding functional maintenance programs and hand contractures proplicy and procedure. A random audit of Functional Maint ROM programs will be conducted by QAPI Coordinator or designee, 1 till weekly for 12 weeks with the care	ector eting eated et. 5, er GSS enance by the		
	worn a splint on he	ed she has never had nor r hand. R4 stated the doctors r from her stroke she would bility.		planning schedule. A random audithose with potential for contractures be conducted 1 time weekly for 12 with the care planning schedule. At	s will weeks		

` '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	I DDE	00/2	0/2021	
			705 SIXTH STREET				
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worked with R4 and after documentation stated R4 or had occupational ther recently had physical the only for lower extremity. are bending towards the and a splint could prever a referral is needed for the Upon interview on 8/25/2 assistant (NA)-A indicate therapy (RT) and R4 gere hallways on Monday, W6 rides the NuStep Tuesda indicated she does not enable hands but indicated she does it herself. During interview on 8/25 indicated NA's are not read to the ROM services as they have do that. NA-B further into a splint but she has not some control of the process of the pro	6/21, at 8:24 a.m., OT) indicated she has not er searching 4 has never had a referral rapy. OT indicated R4 erapy but referral was OT indicated if fingers e palm of her hand, ROM ant further contracture but them to work with R4. 21, at 8:28 a.m., nursing ed she does restorative nerally walks in the ednesday and Friday and ay and Thursday. NA-A exercise either of her thinks R4 sometimes 6/21, at 8:54 a.m., NA-B esponsible for providing have a restorative aide to dicated R4 used to have seen it for awhile. 6/21, at 8:57 a.m., case manager indicated denial for therapy for her mentation it doesn't look or left hand. RN-I er of contractures on R4's applete a referral today for	F 6	results will be reviewed by th committee with appropriate for initiated to ensure solutions a	ollow-up			

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F 688	spent providing director of nursing of had any therapy on The DON indicated they will generally of DON stated RN-A tlook at it during her informed RN-A that responsible for han indicated obviously noticed. R35 R35's facesheet pridiagnoses of major dementia, anxiety at R35's quarterly Min assessment dated cognitively intact, his vision, clear speech understood and correquired supervision transfers, walking a assistance of one stated assistance one stated R35's progress not R35 was seen by a home check. Physishoulder was stiff a difficulty with mobilina fer physical thera fracture. Okay for Careau and contracture.	d. The rest of her hours are ect patient care. 8/26/21, at 9:42 a.m., the (DON) confirmed R4 has not her left hand since admission. once contractures started complete a referral for therapy, hought physical therapy would recent therapy, but the DON cocupational therapy is ds and fingers. The DON this was something no one inted on 8/26/21, included depressive disorder, and high blood pressure. imum Data Set (MDS) 7/23/21, indicated R35 was ad adequate hearing and n, was able to make selfuld understand others. R35 n of one staff for bed mobility, and eating. Required limited staff for toileting, and extensive if for dressing and hygiene. e, dated 7/21/21, indicated physician for a 60-day nursing cian note indicated R35's right and R35 was having more ty. Previously was doing well py due to right humerus of cocupational therapy) a cares due to decreasing	F 6	88				

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F 688	OT was to evaluate strength and should Diagnosis: history of R35's care plan with indicated ADL (active deficit related to we of left humerus fract independently dress R35 would maintain and ADL score thou Interventions did not current level of function be maintained. Intestaff were needed thactivities, such as be eating. R35's progress noted director of nursing (maintenance program programs to skilled the extremities and should program. R35's progress note registered nurse (R been there and wro evaluate and treat a strengthening in arrows R35 progress note indicated waiting for extremity evaluation maintenance program.	lers dated 7/21/21, indicated and treat as indicated for arm der ROM (range of motion). If humerus fracture, right arm. In initiated date of 4/21/21, vity of daily living) self care akness secondary to history ture evidenced by inability to so, groom, bathe and toilet self. In at current level of functioning right the review process. In it identify ways in which to extioning and ADL score would reventions identified how many to assist R35 with various eathing, bed mobility, dressing, and reviewed. Referral in therapy to evaluate upper roulders for possible exercise as dated 7/21/21, written by N)-C indicated physician had the anew order for OT to as indicated for ROM and m/shoulder. In a dated 7/27/21, written by DON or OT orders for upper and set up for functional	F6	88				

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F 688	R35 had a need for intervention to main falls. On 7/22/21, the include: Active range every day PRN (as Care conference in (RN)-B indicated Frehabilitation program should be indicated skilled Of to update residents program which we upper extremity. Care plan with initiaries and with times, PRN. 2. Active range of a cross trainer equip ROM. Settings tole R35's progress not indicated OT compupdate R35's restor During an interview stated she used to "frozen shoulders," would like to have shoulders were still herself without a lot During an interview nursing assistant (r functional maintenance ntain strength and prevent ne care plan was revised to ge of motion for ambulation needed). ote dated 8/5/21, written by 135 remained on a functional am without concerns. the dated 8/6/21, written by DON Thad made recommendations of functional maintenance re to include exercises for ated date of 1/6/21, was to include: motion: seated bilateral upper a dowel. 10 repetitions two motion: NuStep (recumbent ment) for 5 minutes to promote the dated 8/17/21, by (RN)-I bleted an evaluation and would wrative program. If on 8/23/21, at 2:41 p.m., R35 aget therapy and exercises for but not anymore, adding she therapy again. R35 stated her if and she couldn't do things for	F 68	8				

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 688	not been providing aware of. NA-C star for residents, then services at 10:00 a. able to do that if new reviewed functional this term rather than R35 with the DON. been done with R35 7/21/21, were on 8/ would have expected it to be riday unless a resistence expected that there were no refuse When asked what I plan interventions for range of motion: see exercises with a tow PRN, the DON state not scheduled on a flexibility purposes, be done daily Mond stated she did not knot been done - no and acknowledged carried out. The DOR R35 needed exercise prevent her shoulded DON stated two NA maintenance to res Monday through Friexercises might not able to switch from	services to R35 that she was ted she started the day caring switched to restorative m.; however was not always	F6	88				

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F 692 SS=D	Exercise" dated 4/6 Purpose: - to assess and inst coordination, dexter control, neck, trunk range of motion and relate to ability/inde living) - to maintain muscle function - to prevent deforming part - to help maintain number all body systems - to increase streng coordination, activitic control for fall preventegrity. Nutrition/Hydration CFR(s): 483.25(g) (Section 1988) Section 1988 Section 298 Sectio	"Restorative Functional /21 included: "ruct in endurance, strength, rity, activity tolerance, postural, upper and lower extremity disafety in all areas (all areas pendence in activities of daily et one, strength and joint ities caused by inactivity of a formal physiologic function of th, range of motion, y tolerance and postural ention, circulation and skin (Status Maintenance 1)-(3) If nutrition and hydration. tric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and ed on a resident's ressment, the facility must enti- tains acceptable parameters a such as usual body weight or yet range and electrolyte resident's clinical condition his is not possible or resident		688			10/11/21

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F 692	maintain proper hy §483.25(g)(3) Is of there is a nutritional provider orders at It This REQUIREME by: Based on interview facility failed to act the registered dieti implemented for 1 weight gain. Findings include: R35's facesheet pr diagnoses of major dementia, anxiety at R35's quarterly Mir assessment dated cognitively intact, hy vision, clear speed understood and co required supervision weight gain of 5% of or more in last 6 m R35's physician ord monitoring for side such as changes in effects of antipsych weight gain. R35's care plan wit indicated R35 had related to overeatir that R35 would exp	dration and health; fered a therapeutic diet when all problem and the health care herapeutic diet. NT is not met as evidenced of and document review, the when recommendations from tian were identified but not of 1 residents (R35) with inted on 8/26/21, included of depressive disorder, and high blood pressure. Inimum Data Set (MDS) 7/23/21, indicated R35 was ad adequate hearing and h, was able to make selfuld understand others. R35 on of one eating, and had a for more in last month or 10%	F 69	F-692 Correction Order #2965 Corrected Date: October 11, 2021 It is the current policy and proceducts. Windom to monitor resident R35 was re-assessed and their caupdated regarding weight gain by Dietician and Director of Food and Nutrition on Aug. 25, 2021. All residents are at potential risk for deficient practice. A weight gain a conducted the Dietician and the Dof Nursing on Sept. 29, 2021, with care plans of any additional reside weight gain addressed. On Oct. 1 an audit of all dietary recommendation for September will be conducted be Dietician and the Director of Nursiaussure they were implemented. To prevent further potential deficie practice, the dietician will give diet recommendations to the case managers/Director of Nursing. A corder will be obtained and when readiet change form will be processed SS procedure. From the info on change form, the dietary director wupdate the diet card and provide the change information to the dietary	ure of weights. It plan the left with the left with the left with the left with the left will left will left will left will left weight will left weight will left will left will left weight will left will	

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F 692	the review date. Intra R35 and her family and portion size of alternatives to over food, adverse effect. During an interview when asked if she I weight gain, R35 st but didn't know how was concerned abordon't want to gain a R35's measured we weight gain in six m 2/24/21, to 163 pour Nutritional status prand written by regist indicated R35 was chewing or swallow feed herself. R35's showing a gradual since admission in significant weight gathe past six months (considered obese) assessment) score nutritional assessment recommended talking significant weight gather portions in specific lower calor could include no brown is a sandwich, smasmaller portions of	erventions included talking to about healthier snack options snacks; coping behaviors, eating, feelings related to ts of weight gain. on 8/23/21, at 2:45 p.m., nad experienced weight loss or ated she had gained weight, much. When asked if she but that, she stated, "well, I nymore." eights indicated a 12.41% nonths, from 145 pounds on nds on 8/23/21. rogress note dated 4/25/21, tered dietician (RD)-G, on a regular diet, had no ing problems and was able to weight was 152 pounds, and persistent weight gain April 2020, and now a ain of 18 pounds (13.4%) in a R35's BMI was up to 31.8. MNA (mini nutritional was 13, indicating normal ent. The dietician note ng to her family about her ain and recommended ntake, either by providing general, or by starting some ite interventions. Interventions ead at meals unless the menualler portions of potatoes, desserts, lower calorie snack eals and making sure to offer	F6	92	department via the dietary community book. The Dietician and Director of Dietar educate and proctor a post-quiz to dietary employees on Oct. 11, 2021 regarding this process. The Director of Nursing will educate proctor a post-quiz to the case mar on Oct. 11, 2021 regarding this pro Additionally, the case managers wire-educated and will complete a poon Oct. 5, 2021, by the Director of Nursing, regarding the monitoring of weights and appropriate follow-up GSS policy and procedure. An audit of dietician recommendation occur to assure appropriate and time follow-up, will be conducted by the Coordinator or designee, will occur weekly for 12 weeks with the care planning schedule. Audit results were reviewed by the QAPI committee we appropriate follow-up initiated to ensolutions are sustained.	ry will the l e and nagers cess. ll be est-quiz of oer ons will nely QAPI 1 time ill be eith	

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F 692	choices on the card large and medium or recommendations is were noted on the commendations are more a.m., RD-G reviewed from April 2021, and wondering if my recupon? I don't watch my recommends in dietary. You should if they were followed. During an interview dietary supervisor (dietician notes date that RD-G reviewed a month. The document Records Reviewed were in grid format name, nutrition proferecommendation are notification of all nerecommendations on the listed on either was not aware of all from RD-G from April 2018 and 1018 and 1	s reviewed. Serving size I were small, medium and was checked. No by the dietician from 4/25/21, card. interview on 8/25/21, at 9:24 ed her care conference notes distated "I supposed you're commendations were acted a weight gains as closely. I give writing to the DON and be able to look at those to see distribution." on 8/25/21, at 9:36 a.m., DS)-E located two sets of distributions were titled Medical by Consultant Dietician, and with columns for residents being nutrition and follow-up columns for cessary staff. RD-G's were hand-written. R35 was document. DS-E stated she my recommendations for R35 wril. 8 a.m. RD-G called back and a working remotely in April so a director of nursing (DON) an	F 6	92			

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F 692	emails and stated seregarding R35 from any recommendation 4/25/21, had not be nursing and thereform. During an interview stated she spoke to would like smaller provided want to gain any metrying smaller portion. During an interview DON had not been until 8/25, adding the should have been from significant weight good The usual process communicated recommendations to the diet card and restated that process could not explain work and foliation of the provided to the provided to the provided work and resident nutrition structured to the provided work and resident nutrition structured to the provided work and resident nutrition structured to the provided work and resident nutrition and dietician provided work and resident reviewed resident nutrition and resident reviewed resident nutrition and reviewed reviewed reviewed resident nutrition and reviewed	e DON looked back in her she did not have an email of the RD-G. The DON stated ons by RD-G for R35 from the encommunicated to dietary or ore had not been implemented. If 8/25/21, at 10:56 a.m., DS-E or R35 and R35 stated she cortions and agreed she didn't ore weight, and would be okay ons at meal times. If on 8/26/21, at 11:32 a.m., the aware of R35's weight gain that RD-G's recommendations ollowed through when R35's ain had been identified in April. If or this was the dietician of the properties of the carried out; e.g., added to esident's care plan. The DON did not happen this time and	F 69			10/11/21
SS=D	CFR(s): 483.45(c)(

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F 758	affects brain activiti processes and beh but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; an (iv) Hypnotic Based on a compressed on a compressed on a compressed on the facility \$483.45(e)(1) Residual psychotropic drugs unless the medication and in the clinical record \$483.45(e)(2) Residual psychotropic drugs receive grade behavioral intervence contraindicated, in a drugs; \$483.45(e)(3) Residual psychotropic drugs unless that medicated diagnosed specific in the clinical record \$483.45(e)(4) PRN are limited to 14 da \$483.45(e)(5), if the prescribing practitic appropriate for the	cropic Drugs. Archotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following chensive assessment of a must ensure that dents who have not used are not given these drugs on is necessary to treat a s diagnosed and documented di; dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented	F 75			

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F 758	§483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practitic the appropriatenes. This REQUIREMED by: Based on interview facility failed to ensureduction (GDR) of was attempted or reduction (GDR) of was attempted or reviewed for unneces. R57's Admission R indicated diagnosis disorder and demedisturbance. R57's change of continuous completed by staff symptoms of depresent the physician" dated 4/4 admitted 11/2/20 w (used to treat depredepressive disorder depresent the present the continuous continuous completed by staff symptoms of depresent depresent disorder disorder disorder depresent disorder disorder depresent disorder disord	dent's medical record and n for the PRN order. orders for anti-psychotic 14 days and cannot be attending physician or oner evaluates the resident for sof that medication. NT is not met as evidenced a and document review, the ure a timely gradual dose a psychotropic medication ationale provided for current or 1 of 5 residents (R57) ressary medication use. ecord printed 8/25/21, including major depressive that without behavioral andition Minimum Data Set adated 8/24/21, identified R57 red cognition, exhibited no red a 4/27 on Patient Health Q)-9 (Major depressive red to diagnose depression), and indicating minimal	F 758	F-758 Corrected Date: October 11, 2021 It is the current policy and procedur GSS-Windom to review residents funnecessary medication use. The physician for R57 had reviewe consultant pharmacist communicate adjusted the medication on July 21 All residents are at risk for this defining practice. All resident consultant pharmacist communications from A 2021, were reviewed by the Director Nursing and Case Managers on Se 2021 for an outstanding medication recommendations. None were four To prevent further potential deficient practice, the Director of Nursing where the dissemination of the recommendations to the physicians the required time frame. The Case Managers will be re-educated will complete a post-quiz by the Director of Nursing on Oct. 5, 2021 Oct. 11, 2021, regarding appropriate.	d the cion and , 2021. cient Aug. 30, or of ept. 29, or ond. at the content of t	

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		245558	B. WING			26/2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 758	within the antidepreresponse to this coincluded escitalopra written order did no written justification same dose. R57's Physician Or escitalopram oxalated ascitalopram oxalated R57's Physician Or escitalopram oxalated R57's Physician Or escitalopram oxalated R57's plan of care, the resident is on magency boxed warm consequences related A Medication Reconsequences related A Medication Reconsulty daily through During interview on director of nursing in pharmacist marks a medication review to the recommendations of the time did seem long. During interview on consultant pharmacity to reduce the period to reduce t	ders dated 5/21/21 included the Tablet 10 mg daily. ders dated 6/21/21 included the Tablet 10 mg daily. ders dated 7/21/21 included the Tablet 10 mg daily. ders dated 7/21/21 included the Tablet 10 mg daily. ders dated 7/21/21 included the Tablet 5 mg daily. ders dated 7/21/21 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily. last revised 2/3/2021 included the Tablet 5 mg daily.	F 758	timely follow-up for the consultant pharmacist recommendations to physicians per GSS policy and process poli	rocedure. acist to ensure Il be tion y times 4 he end of s us month results nmittee	

STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY PLETED
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NAME OF PROV	/IDER OR SUPPLIER	243330	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	08/2	26/2021
	ARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 790 SS=D CF \$44 A f. \$44 del res	necessary drugs. aradual Dose Recessary drugs. aradual Dose Recessary drugs. The purpose of an optimal dose e of the medication of the medication of the medication had derlying causes of the resolve and/or erventions have be mptoms. The structure of the medical condition had derlying causes of the resolve and/or erventions have be mptoms. The structure of the s	ductions: If tapering medication is to e or to determine if continued on is benefiting the resident. Idicated when the resident's improved or stabilized, the of the original target symptoms in non-pharmacological open effective in reducing the potential Srvcs in SNFs The Dental Srvcs in SNFs	F 7	58		10/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245558	B. WING		08/2	6/2021
	PROVIDER OR SUPPLIER	- WINDOM	7	STREET ADDRESS, CITY, STATE, ZIP CODE 105 SIXTH STREET VINDOM, MN 56101	00/2	0/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 790	assist the resident; (i) In making appoi (ii) By arranging for dental services loc §483.55(a)(5) Mus residents with lost dental services. If a 3 days, the facility what they did to en and drink adequate services and the ex led to the delay. This REQUIREME by: Based on observa review, the facility recommendations appointments coor service for 1 of 1 re dental care. Findings include: R30's facesheet pr diagnoses of Parki nervous system dis and diabetes (met body has high suga of time). R30's significant ch (MDS) assessmen had moderate cogn difficulty hearing, a was able to make s	t if necessary or if requested, ntments; and transportation to and from the	F 790	F-790 Correction Order #21325 Corrected Date: October 11, 2021 It is the current policy and procedur GSS-Windom to follow-up on denta referrals in a timely manner. A dental appointment was re-sched for R30 on Sept. 21, 2021. All clients are at risk for this deficient practice. On Sept. 30, 2021, the Diof Nursing and Case Managers revall client records for unmet dental reand no others were found. To prevent further potential deficient practice, the Case Managers will tradental appointments via the nurse of system in PCC, which can generate reminder order for follow-up on a dechoose.	duled nt irector riewed eferrals nt ack order e a	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2	20/2021
					705 SIXTH STREET		
GOOD S	AMARITAN SOCIETY	- WINDOM			WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 790	Continued From pa	ge 22	F 7	'90			
	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				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		
	up/supervision for contervention with revindicated R30 used	oral care. Plan of care vised date of 8/10/21, a divided plate and plastic ting. No mention of dental			entering a future doctor's order for appointments which provides a mechanism to assure is follow-up i completed. An audit of dental referrals and		
	buring 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."				appropriate follow-up will be conduthe QAPI Coordinator or designee, weekly for 12 weeks with the care planning schedule. Audit results wereviewed by the QAPI committee wappropriate follow-up initiated to ensolutions are sustained.	1x ill be vith	
	had attended a rout day. Progress notes indicated R30 had ha a filling. Notes indic oral surgery for extra following extraction partial denture. Las	n dated 2/17/21, indicated R30 ine dental appointment that is hand-written by dental staff and an initial exam, xrays and cated a referral was made to faction of tooth #20; and teeth would be added to his tly, the facility was to call to ent after the extraction.					
	4/6/21, indicated R3	/dental assessment dated 30 had a partial lower bridge are and had a pending [dental]					
		onic note dated 4/14/21, from ed R30 had an odentectomy					

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRICE OF THE	LD BE	(X5) COMPLETION DATE
F 790	instructions include follow-up. R30's care confered 10:37 a.m. indicate daughter (via phone recreation/wellness worker (LSW)-A. R conference note indicouple weeks ago a was in need of a neighbor plate went missing daughter was not colikely be getting a newer extracted. R30's annual oral/d7/6/21, indicated R3 and a partial lower appointment for following an interview administrative receappointments for readental appointment a folder and stated appointment schedittled: Appointment completed by RN-Adaughter requested as possible. The foa hand-written nota 4th." AR-F stated Rappointment. AR-F appointment had be appointment.	ooth #20, and follow up d to continue local dentist ance note dated 4/29/2021, at d attendance by R30's e), registered nurse (RN)-A, is (RW)-A, licensed social 30 declined to attend. Care dicated R30 saw the dentist a and had teeth extracted. R30 ew denture plate as his denture some time ago. R30's oncerned since R30 would ew plate anyway since teeth lental assessment dated 30 had a partial upper bridge bridge and had a pending low-up dental work. If on 8/24/21, at 2:28 p.m., ptionist (AR)-F who made esidents was asked if R30 had nt scheduled. AR-F looked in no, he did not have a dental uled. AR-F presented a form and Ride Request Intake, which indicated resident and d a dental appointment as soon rm was not dated. There was tion in pencil: "Eyes 1st Aug 30 wanted to wait till until after at on 8/4/21, to go to the		90		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COM	X3) DATE SURVEY COMPLETED			
		245558	B. WING _			C 26/2021
	PROVIDER OR SUPPLIER	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101	, 33.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 790	dental instructions in make another apport extracted, and his to 4/14/21. During an interview DON stated she has sequence of events dental appointment AR-F had just mader R30. "It seems it shooner." When ask to act upon follow-ut the DON stated nur AR-F know to make not sure what happ was dropped. The loom completed the Appointake form had not so the form which in had requested a depossible, would have or earlier than that.	aware that R30's 2/17/21, ndicated the facility was to bintment after his tooth was ooth was extracted on on 8/26/21, at 10:58 a.m., the d not been aware of the sthat occurred with R30's so until this day, but was aware a dental appointment for would have been made ed who reviewed dental notes up instructions by the dentist, reses would do that and let at the appointment. DON was ened this time that the ball DON stated RN-A, who bintment and Ride Request at worked since early July 2021, andicated R30 and his daughter ental appointment as soon as we been filled out in early July The DON confirmed the d have been made sooner,	F 79			
	appointments for re	Store/Prepare/Serve-Sanitary	F 81	2		9/29/21
		cure food from sources ered satisfactory by federal,				

A. BUILDING		PLETED					
		245558	B. WING				C 26/ 2021
-	PROVIDER OR SUPPLIER	- WINDOM		705 9	EET ADDRESS, CITY, STATE, ZIP CODE SIXTH STREET DOM, MN 56101		
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F 812	(i) This may include from local produce and local laws or re (ii) This provision of facilities from using gardens, subject to safe growing and from consuming for safe growing and from consuming for \$483.60(i)(2) - Store from consuming for serve food in accordance from serve food in accordance from consuming for standards for food This REQUIREME by: Based on observation to the appropriate is safety and prevent deficient practice for residents, staff and the kitchen. Findings include: During observation cook (C)-A indicate out of the oven "aw steam table, but we time. C-A stated he chicken and do temperature" book Fahrenheit (F) with indicated he check about 20 minutes pasteam table and statemperature about	e food items obtained directly rs, subject to applicable State egulations. loes not prohibit or prevent g produce grown in facility compliance with applicable bod-handling practices. does not preclude residents ods not procured by the facility. Te, prepare, distribute and rdance with professional	F8	F C It G ir C for the p C to the te	F-812 Corrected Date: Sept.29, 2021 is the current policy and proceducts. Windom to take food temperature accordance with regulations. On Aug. 24, 2021, when the food wound to not be at the appropriate emperature, the food was immedial laced back in the oven for further ooking, until it reached the proper emperature. All meals are at risk for this deficient actice. The Director of Food and lutrition, with assistance from the Dietician, updated the mealtime for emperature log to include time the emperature was taken. They also podated the food temperature processing include additional temperature to mes, such as between loading the not the carts.	atures vas ately nt l cedure aking	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245558	B. WING _			08/2	26/ 2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM	STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101			00/2	- O/ E O E 1
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F 812	p o	ge 26 I on 8/24/21, at 11:23 a.m., per	F 8	12	To prevent further potential deficien	t	
	request, C-A check which was 110 deg chicken temperatur was 124 degrees F	ed temperature of chicken, rees F. C-A rechecked e in another location and it . C-A indicated he will have to oven and proceeded to do so.			practice, the cooks were educated of Sept 29, 2021, by the Director of Formand Nutrition and the Consulting Director GSS policy and procedur taking and recording food temperat	on ood etician e for	
	11:36 a.m., C-A ren convection oven an which was 115 deg present when unco chicken back into the indicated the oven	and interview on 8/24/21, at noved the chicken from the id rechecked temperature rees F. There was no steam vered. C-A then placed ne convection oven and had been off so likely wasn't lly placed in the oven.			The proper completion of food temperature logs will be audited 3 to weekly times 4 weeks and then 1 to weekly for 8 weeks by the Director of Food and Nutrition or designee. At results will be reviewed by the QAP committee with appropriate follow-unitiated to ensure solutions are sustained.	me of Idit I	
	11:49 a.m., C-A ren convection oven wi F. C-A tried two dif maybe the thermon change in temperat coming from pan of they have been have	and interview 8/24/21, at noved chicken from the th temperature at 128 degrees ferent thermometers stating neter was not accurate with no ture. Observed no steam f chicken. C-A then indicated ring some issues with the placed chicken back in					
	12:05 p.m., C-A rer and upon checking	and interview 8/24/21, at noved chicken from the oven temperature of chicken it read eam was present coming from					
	rechecked tempera steam table to main at 165 degrees F.	24/21, at 12:32 p.m., C-A ture of chicken prior to moving a dining room with temperature C-A confirmed he would not emperature prior to beginning					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101	1 00/1	20/2021
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F 812	serving the chicken had done so 20 mir Review of food tem 8/24/21, at 12:41 p. food product check were below 38 degr 165 degrees F or hithe August. During interview on dietary supervisor (should be checked the foods. A policy and proceed Monitoring" dated 4	from the steam table as he nutes prior to my arrival. perature monitoring log on m., did not include time, or ed but all cold temperatures rees and all hot foods were igher since the beginning of 8/26/21, at 11:11 a.m., the DS) indicated temperatures immediately prior to serving	F 8	12		
F 880 SS=F	before each meal s temperatures are ta the end of meal ser are held within acce - Chicken, turkey, s pasta, stuffed poult degrees instantane - Hot foods should I higher. Infection Prevention CFR(s): 483.80 (a)(§483.80 Infection C The facility must es infection prevention designed to provide comfortable environ	ervice. Periodically, aken at other times during or at vice to ensure temperatures eptable ranges. tuffing, stuffed meats, stuffed ry heating temperature is 165 ous one served at 135 degrees F or a & Control (1)(2)(4)(e)(f) control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable	F 8	30		10/8/21

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 880	program. The facility must es and control program a minimum, the following services and communicable staff, volunteers, visproviding services arrangement based conducted accordinaccepted national signature of the but are not limited to (i) A system of survices arrangement based conducted accordinaccepted national signature of the but are not limited to (ii) A system of survices possible communication infections before the persons in the faciliation (iii) When and to who communicable diservices (iiii) Standard and transition to be followed to province of the persons in the faciliation of the persons in the faciliation of the persons in the faciliation of the followed to province of the persons in the faciliation of the followed to province of the persons in the faciliation of the followed to province of the followed to province of the faciliation of the fac	n prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment ing to §483.70(e) and following standards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; som possible incidents of ease or infections should be ansmission-based precautions event spread of infections; solation should be used for a	F 88	,		
	involved, and (B) A requirement to least restrictive post circumstances. (v) The circumstance	e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE	
		245558	B. WING _		C 08/26/2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101	00/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 880	disease or infected contact with resider contact will transmi (vi)The hand hygier by staff involved in §483.80(a)(4) A sysidentified under the corrective actions to §483.80(e) Linens. Personnel must had transport linens so infection. §483.80(f) Annual ransport linens so infection. Findings include the spead of covidensure personal propriately imples the spread of Covidensure personal proprincluding mask wo facility failed to sepfrom vaccinated residual to affe in the facility. Findings include: Unvaccinated Residual contact of the potential to affe in the facility.	skin lesions from direct hts or their food, if direct to the disease; and he procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the aken by the facility. Indle, store, process, and has to prevent the spread of the eview. Iduct an annual review of its heir program, as necessary. In its not met as evidenced hion, interview and document healled to follow Centers for caid Services (CMS) and he Control (CDC) guidelines by menting measures to prevent D-19 when the facility failed to precive equipment (PPE) on correctly, and when the hearate an unvaccinated resident sidents at meal time. This had cot all 60 residents who resided	F 88	F-880 Correction Order #21375 Corrected Date: October 8, 2021 On Aug. 24, 2021, R46 was placed personal table, 6 feet away from ot residents, but facing them. This arrangement continues. Staff on dothe time of the incident were imme re-educated by the Activity Director the Director of Nursing. No other residents at the time of su were unvaccinated. One short-terr is currently unvaccinated and their situation follows appropriate guidel All staff present on Aug. 23, 2021, immediately re-educated regarding mask use and were provided with	her uty at diately and urvey n client dining ines. were

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245558	B. WING		08/2) 26/2021
	PROVIDER OR SUPPLIER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101	1 00/20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 880	facility, R46, was not buring an observal R46 was observed approximately 4 fe station dining room R25 and R30. Non masked. During an interview at 8:50 a.m., observance in the nurses other residents, R2 nurse (LPN)-B state were any unvaccinated residents and word was eating breakfastation dining room asked if it was okato eat in close proystated, "I don't known done." During an interview DON was asked we resident, R46, ate she was aware of unvaccinated resident resi	age 30 ot vaccinated for Covid-19. tion on 8/23/21, at 5:57 p.m., eating at a small square table, et by 4 feet, in the nurses a. At the table with R46 was e of the residents were v and observation on 8/24/21, rved R46, the facility's only lent, eating at a small, square station dining room with two 25 and R30. Licensed practice ed she did not know if there ated residents in the facility; call the front desk to find out. re if vaccinated and lents could eat together at the build have to ask the DON. v on 8/24/21, at 8:52 a.m. awas only one resident on the d not been vaccinated for was R46. RN-I confirmed R46 ast at a table in the nurses a with R25 and R30. When by for an unvaccinated resident cimity to other residents, RN-I wthat's what we've always v on 8/24/21, at 11:37 a.m., the here the unvaccinated her meals. The DON stated CDC guidance that lents should be six feet away sidents when eating. The DON a pattern of coming out of her	F 880	different style mask if needed to e proper fit. Any new unvaccinated residents wat risk for this deficient practice. A clients upon admission are assess vaccination status and will dine in accordance with GSS policy and procedure aligning with current stafederal guidelines. All residents would be at risk for stafederal guidelines. All residents would be at risk for stafederal guidelines. All residents would be at risk for stafederal guidelines. Root Cause Analysis was conduct Sept. 22, 2021, by the QAPI commincluding the Infection Preventionis was reviewed and approved by the Samaritan Society Nursing and Cl Services Consultant and the Good Samaritan Society Quality Improve Advisor. All policies and procedures for PP during the COVID-19 pandemic, in source control masks, proper use gowns, and transmission-based precautions, were reviewed and for be appropriate. To prevent further potential deficie practice of unvaccinated resident of clients who are unvaccinated will caccordance with the current CMS QSO-20-39-NH. Notice of these coposted at the nurse's stations on withey reside, as well as outside the door with a purple precautions signall staff were re-educated Oct. 4-8 through learning boards and a positive developed by the Administrator. Dispense of the second developed by the Administrator.	vould be all sed for ate and taff not y. A ed on nittee, st and e Good inical I ement E usage ncluding of bund to nt dining, dine in elients is which ir room n. S. 2021, st-quiz	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245558	B. WING		08/3	26/ 2021
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	00/2	20/2021
_				705 SIXTH STREET		
GOOD S	AMARITAN SOCIETY	' - WINDOM		WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 880	Continued From pa	age 31	F 880			
	accommodatene picturelikes to ea stay long." The DC team about other of team at the station diniform a table with F been set up for R4 with her name on it was not isolated at hear other resident Facility policy titled Long-term Care In facilities and Assist the State department indicated if unvacced during communal of tesidents should under the picture.	tion on 8/24/21, at 12:54 p.m., ng at a table by herself in the ng room, at least six feet away 125 and R30. Another table had 6, and the table had a placard tin the center of the table. R46 nd was still able to see and ts and staff. Covid 19 Guidance: door Visitation for Nursing ted Living-type settings from ent of health, dated 5/20/21, inated residents are present dining or activities, then all see face coverings when not		of Nursing, and a Case Manager, regarding the current requirement unvaccinated resident dining and system for knowing who is unvaccinated for the prevent further potential deficie practice of mask wearing, all empwere re-educated through lecture, demonstration, and competency to the Clinical Learning and Deve Specialist on Sept. 28-30, 2021, restandard infection control practice including transmission-based precappropriate PPE use, and donning doffing PPE. Residents and their representative educated via email/postal mail/rood delivery on Oct. 1, 2021, and in perform of the Administrator and Infection Preventionist regarding the facility infection control program, including responsibilities.	the cinated. ent loyees esting, lopment egarding s, cautions, g and es will be om erson on ncil by	
	Mask Observation On 8/23/21, the folwere made: of stafwere not appropria At 1:42 p.m., admiwas observed with At 1:38 p.m., the dobserved with mas At 2:31 p.m., nursi observed with mas At 3:19 p.m., DON wear mask below	lowing mask observations f and visitors in the facility who tely wearing face masks. nistrative receptionist (AR)-F mask below nose. irector of nursing (DON) was sk below nose. ng assistant (NA)-D was sk below nose. was observed to continue to		Any unvaccinated resident dining situations will be randomly audited QAPI Coordinator or designee, 3 is per week at various meals for 4 withen 1 time per week for 8 weeks. The QAPI Coordinator and designaudit in the following manner. A mof 10 times per week for 4 weeks, times per week for 8 weeks or unt compliance is sustained; covering shifts and multiple departments. It audited will include, employees, viand residents. Items to be audited include, but are not limited to: do and doffing of PPE with transmission-based precautions,	times eeks, lees will inimum then 5 iil multiple People sitors, d	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245558	B. WING				C 26/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2	20/2021
					05 SIXTH STREET		
GOOD S.	AMARITAN SOCIETY	- WINDOM		V	/INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	with mask below no At 5:45 p.m., (NA)-l below nose. At 5:50 p.m., While activities (A)-B bend in front of R47 in his from his unmasked below her chin to ta At 6:11 p.m., observesident in the dining feeding him, wearing At 6:27 p.m., observesident in the dining feeding him, wearing the 500 wing assist was below chin. Where the 500 wing an interview director of nursing (asked what the expenses, was it okay nose. The DON at the the the the the the the the the th	k below nose. enance (M)-A was observed ose. E was observed with mask in R47's room, observed d forward at the waist, directly s wheelchair, about one foot face and pull down her mask alk to him about supper. wed a female visitor of a reg room on the 500 wing, reg mask below her nose. wed NA-E in the dining room of ing a resident to eat. Mask nen saw surveyor, pulled mask on 8/23/21, at 6:40 p.m, the EDON) and administrator were rectation was for staff wearing for them to be worn below the ated no, it was not acceptable rect way to wear a mask for rposes. The DON stated up on her face, as she et talking. The administrator	F8	80	aerosolized generating procedures ensure PPE is used, and proper us PPE gowns. All audit results will be reviewed by QAPI committee with appropriate follow-up initiated to ensure solutio sustained.	the	
	observed the DON	ion on 8/23/21, at 7:10 p.m., handing out masks to some to them about wearing masks					

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245558	B. WING			C / 26/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101		20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 880	Long-term Care Inc facilities and Assiste the State departme indicated staff were facemask that fully in accordance with	Covid-19 Guidance: loor Visitation for Nursing ed Living-type settings from nt of health, dated 5/20/21, to wear a well-fitting covers the mouth and noise, CDC guidance. residents stance from others.	F8	80		



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

Good Samaritan Society - Windom September 21, 2021 Page 2

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

M. Flig

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

(X6) DATE

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___

		00085	B. WING		C 08/26/2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY - WIND	OOM 705 SIXTH	DRESS, CITY, S I STREET MN 56101	STATE, ZIP CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST I REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE COMPLETE
2 000	Initial Comments ******ATTENTION NH LICENSING CORF In accordance with Minne 144A.10, this correction of pursuant to a survey. If, to found that the deficiency of herein are not corrected, and corrected shall be assemith a schedule of fines possible the Minnesota Department. Determination of whether corrected requires compliance and MN Rule number and MN Rule number and MN Rule number and MN Rule number and may require that was violated during the corrected. You may request a hearing that was violated during the corrected. You may request a hearing that may result from non-orders provided that a writh the Department within 15 notice of assessment for instance of assessment for instance of assessment for instance of assessment of facility was found NOT in State Licensure and the foorders are issued. Please electronic plan of corrections.	sota Statute, section rder has been issued upon reinspection, it is or deficiencies cited a fine for each violation essed in accordance romulgated by rule of at of Health. a violation has been ance with all rovided at the tag ober indicated below. eral items, failure to ms will be considered of compliance upon of multi-part rule will of a fine even if the item he initial inspection was gon any assessments compliance with these ten request is made to days of receipt of a non-compliance. licensing survey was by surveyors from the Health (MDH). Your compliance with the MN ollowing correction indicate in your	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 10/01/21

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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2 000	Continued From pathese orders, and ide completed. The following compuNSUBSTANTIATE (MN00051263), H5: Minnesota Department the State Licensing federal software. Taxisigned to Minnes Nursing Homes. The appears in the far leading to the correction order the findings which a statute after the statute after the statute after the statute as evidence by." For are the Suggested I Time period for Correction order the Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. It is necessary for State enter the word "corrected prior to el Minnesota Department of Heal you electronically. I	laint were found 15: H5558028C (MNO 15: 15: 15: 15: 15: 15: 15: 15: 15: 15:	d to be 30058952). I documenting ers using re been res/rules for number red "ID Prefix compliance is of Deficiencies" oly" portion of also includes of the state reliable is not met reyors findings rection and re electronic resistent with the ble at respective of the state of the state respective of the state o	2 000			

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Minnesota Department of Health STATE FORM

PELM11 If continuation sheet 2 of 28

Minnesota Department of Health

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE S	
	00085				08/2	; 6/2021
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2 000	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO MINNESOTA STAT	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF	2 000			10/8/21
2 090	Motion Subp. 2. Range of that is directed toward through positioning implemented and motion comprehensive results of nursing services development of a motion provides that: B. a resident with receives appropriate	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which h a limited range of motion e treatment and services to notion and to prevent further	2 093			10/6/21
	by: Based on observati review the facility fa motion program for implemented for 2 of reviewed who had I Findings include: R4's face sheet, pri	on, interview and document alled to ensure a range of upper extremities was of 2 residents (R4, R35) imited range of motion.		Correction Order #2895 Corrected Date: October 8, 2021 It is the current policy and procedu GSS-Windom to provide ROM as to residents. On Aug. 30, 2021, R4 was referred therapy, who assessed and applied splint on Aug. 30, 2021. The care	needed d to d a	

Minnesota Department of Health

STATE FORM PELM11 If continuation sheet 3 of 28

Millinesc	Innesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
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2 895	Continued From pa	ge 3	2 895				
		ondition that affects blood flow e event affecting left		and treatment record were update reflect the new splint.			
	intact cognition, lim upper and lower ex required extensive transfers, bed mobil assist of one for pe R4's care plan, date 7/22/21, indicated F maintenance prographysical mobility relineeding assistance ambulation. Interve of motion to include train exercise machambulate with 1 assistance ambulate with 1 assistance.	5/21/21, identified R4 had ited range of motion of both tremities on one side and assist of 2 or more persons for ility and toileting and extensive rsonal hygiene. ed 9/30/19, and last updated R4 had a need for a functional am due to deficit and limited lated to left hemiplegia and with transfers and entions included active range entions included active range entions two times per week and sist and wheelchair to follow at		For R35, on Sept. 22, 2021, the furmaintenance program was revised reflect current needs. The revised program was attempted for 1 weel poor outcomes. R35 was then ref back to therapy on Sept. 30, 2021 further assessment. All clients at risk for contractures we evaluated for additional service ne Appropriate care plan updates were completed by the Case Managers 29-Oct. 1, for anyone found to be a All clients on functional maintenant services are at risk for this deficier practice. All functional maintenant programs were assessed and updated Sept. 29-Oct. 1, 2021 by the contraction of the services are at risk for this deficier practice.	d to were eds. Sept. at risk. ce nt ce ated as		
	no plan of care add left upper extremition 3:16 p.m., R4 was shand lying on her la and 5th finger bent but not touching. Umove her left finger assistance from he do not do any ROM does she have a spleg works better that having therapy for hinished physical the walking.	erate as needed. There was lessing passive ROM or R4's es. and interview on 8/23/21, at sitting in a recliner with left ap, with thumb, middle finger towards the palm of the hand loon request R4 was unable to rs, hand or arm without r right hand. R4 indicated they I on her left hand or fingers nor olint. R4 further stated her left an her arm and does not recall her upper extremity, but just erapy for transfers and and interview on 8/25/21, 7:34		Director of Nursing and the Case Managers. To prevent further potential deficie practice, all nursing staff were recont. 4-8, 2021, through learning be and a post-quiz developed by the Administrator, Director of Nursing, Case Manager, regarding the import completing ROM programs and contractures. The case managers will be re-edu and will complete a post-quiz on Case 1, by the Director of Nursing, refunctional maintenance programs hand contractures per GSS policy procedure. A random audit of Functional Main	educated pards and a prtance cated loct. 5, egarding and and		

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S	
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NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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2 895 Continued From page 4 a.m., R4's left thumb, middle bent in towards the palm of hindicated she does not recall working with her hand since facility. R4 confirmed she haworn a splint on her hand. R told her after a year from her not regain any mobility. During interview on 8/25/21, occupational therapist (OT) i worked with R4 and after sea documentation stated R4 has or had occupational therapy. recently had physical therapy only for lower extremity. OT are bending towards the palmand a splint could prevent fur a referral is needed for them Upon interview on 8/25/21, a assistant (NA)-A indicated sh therapy (RT) and R4 general hallways on Monday, Wednerides the NuStep Tuesday ar indicated she does not exercity hands but indicated she think does it herself. During interview on 8/25/21, indicated NA's are not responsed to that. NA-B further indicate a splint but she has not seen. During interview on 8/25/21, registered nurse (RN)-I case she recently gave R4 a denial lower leg, and per document.	therapy ever she has been at this is never had nor 4 stated the doctors stroke she would at 8:24 a.m., indicated she has not arching so never had a referral OT indicated R4 but referral was indicated if fingers in of her hand, ROM other contracture but to work with R4. It 8:28 a.m., nursing the does restorative ly walks in the saday and Friday and and Thursday. NA-A ise either of her is R4 sometimes at 8:54 a.m., NA-B insible for providing a restorative aide to ed R4 used to have it for awhile.	2 895	ROM programs will be conducted QAPI Coordinator or designee, 1 to weekly for 12 weeks with the care planning schedule. A random audithose with potential for contracture conducted 1 time weekly for 12 we with the care planning schedule. A results will be reviewed by the QA committee with appropriate follow initiated to ensure solutions are sufficient to the conducted of the conducted of the conducted of the care planning schedule. A results will be reviewed by the QA committee with appropriate follow initiated to ensure solutions are sufficient to the conducted of the care planning schedule. A random audithose with potential for contracture conducted 1 time weekly for 12 we with the care planning schedule. A results will be reviewed by the QA committee with appropriate follow initiated to ensure solutions are sufficient to the conducted of the care planning schedule.	time lit of les will be leeks ludit PI -up	

Minnesota Department of Health

STATE FORM PELM11 If continuation sheet 5 of 28

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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2 895	Continued From pa	ge 5		2 895			
		aware of contractures I complete a referral					
	indicated she does a.m. until 2:00 p.m.	8/25/21 at 9:33 a.m. restorative therapy from the doesn't always of the rest of her hoect patient care.	om 10:00 get all the				
	director of nursing of had any therapy on The DON indicated they will generally of DON stated RN-A took at it during her informed RN-A that responsible for han	8/26/21, at 9:42 a.m (DON) confirmed R4 her left hand since a once contractures somplete a referral for hought physical there recent therapy, but to occupational therapy ds and fingers. The this was something in	has not dmission. tarted r therapy. apy would he DON y is DON				
	R35						
	diagnoses of major	nted on 8/26/21, included an 8/26/21, included the depressive disorder, and high blood pressu	ı				
	assessment dated cognitively intact, h vision, clear speech understood and correquired supervisio transfers, walking a assistance of one sassistance one state R35's progress not	imum Data Set (MDS 7/23/21, indicated R3 ad adequate hearing n, was able to make suld understand others n of one staff for bed and eating. Required taff for toileting, and if for dressing and hy e, dated 7/21/21, indiphysician for a 60-dated 7/21/21.	s was and self s. R35 mobility, limited extensive giene.				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
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2 895	Continued From particles home check. Physics shoulder was stiff a difficulty with mobility after physical theral fracture. Okay for corder for restorative mobility and strength and strength and should Diagnosis: history of the corder for restorative mobility and strength and should Diagnosis: history of the corder for restorative mobility and strength and should Diagnosis: history of the corder for restorative mobility and strength and should Diagnosis: history of the corder for restoration of the corder for restoration of the corder for th	cian note indicated R35 was have ty. Previously we by due to right have cares due to detail the cares due to detail the initiated date of humerus fract in initiated date of humerus fract in initiated date of humerus secondature evidenced and the review post identify ways in the review of the review of the review post identify ways in the review of	ving more as doing well numerus I therapy) ecreasing 21, indicated dicated for arm of motion). ure, right arm. of 4/21/21, g) self care ary to history by inability to and toilet self. I of functioning process. In which to be score would fied how many the various bility, dressing, written by functional eferral in ate upper lible exercise written by ohysician had for OT to	2 895			

Minnesota Department of Health

STATE FORM PELM11 If continuation sheet 7 of 28

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
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NAME OF I	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	MN 56101			
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2 895	Continued From pa	ge 7	2 895			
	R35 progress note indicated waiting fo	dated 7/27/21, written by DON r OT orders for upper and set up for functional				
	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.					
	revised on 8/6/21, t 1. Active range of n arm exercises with times, PRN. 2. Active range of n	notion: seated bilateral upper a dowel. 10 repetitions two notion: NuStep (recumbent ment) for 5 minutes to promote				
		e dated 8/17/21, by (RN)-I leted an evaluation and would rative program.				
	stated she used to "frozen shoulders," would like to have t	on 8/23/21, at 2:41 p.m., R35 get therapy and exercises for but not anymore, adding she herapy again. R35 stated her and she couldn't do things for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00085		B. WING			C 26/2021	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
COODS	GOOD SAMARITAN SOCIETY - WINDOM 705 SIXTH STREET							
GOOD S	AMARITAN SOCIETY	- WINDOW	WINDOM,	MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN(' MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 895	Continued From pa	ge 8		2 895				
	herself without a lot	or pain.						
	During an interview nursing assistant (N provided restorative not been providing aware of. NA-C stat for residents, then a services at 10:00 a. able to do that if new During an interview	IA)-C stated she as services to reside services to R35 the started the switched to restorate,; however was eded on the floor.	and (NA)-A ents, but had at she was e day caring ative not always					
	reviewed functional this term rather than R35 with the DON. been done with R35 7/21/21, were on 8/ would have expected.	maintenance (the n restorative service The only date exe is since the new or 8/21. The DON sta	facility used ces) form for rcises had der on ated she					
	she expected it to be Friday unless a resistence she expected that to there were no refus	e done daily, Mon dent declined or re be documented.	day through efused, then Informed					
	When asked what F plan interventions for range of motion: se	PRN meant in rela or R35, for examp ated bilateral uppe	tion to care le: Active er arm					
	exercises with a tov PRN, the DON state not scheduled on a	ed it meant exerci	ses where					
	flexibility purposes, be done daily Mond stated she did not k	ay through Friday	. The DON					
	not been done - no and acknowledged	one had informed physician orders r	her of this, needed to be					
	carried out. The DC R35 needed exercis	ses to maintain str	ength and					
	prevent her shoulded DON stated two NA	s provided function	onal					
	maintenance to res Monday through Fri exercises might not	day. The DON ad	mitted					

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - WINDOM (K4) ID PREPIX TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCIES BY FREE TADDRESS, CITY, STATE, ZIP CODE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CONTINUED TO SUMMARY STATEMENT OF DEFICIENCIES TAG CHOCKS-REFERENCED TO THE A PPROPRIATE DIA STATEMENT OF DEFICIENCY) 2 895 CONTINUED 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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		SURVEY PLETED
GOOD SAMARITAN SOCIETY - WINDOM 705 SIXTH STREET WINDOM, MN 56101 [X4] ID SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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			00085	B. WING			_
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			- WINDOM 705 SIX	TH STREET	STATE, ZIP CODE		
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	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETE
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	able to switch from maintenance work, often. Facility policy titled Exercise" dated 4/6 Purpose: - to assess and inst coordination, dexter control, neck, trunk range of motion and relate to ability/indeliving) - to maintain muscle function - to prevent deform part - to help maintain nuscle function - to prevent deform part - to increase streng coordination, activitic control for fall prevent integrity. SUGGESTED MET The director of nurser review/revise policies implementation of review/revise policies implemented. The on the policies and evaluating and more implementation of the developed, with the brought to the facilic Committee for review TIME PERIOD FOR	NA work to functional but that would not happen "Restorative Functional 5/21 included: truct in endurance, strength, rity, activity tolerance, postur, upper and lower extremity disafety in all areas (all areas pendence in activities of dail e tone, strength and joint ities caused by inactivity of a cormal physiologic function of the thickness of the tolerance and postural ention, circulation and skin the tolerance and postural ention, circulation and skin the tolerance and procedures related to the tolerance and procedures related to the tolerance and interventions are being DON could re-educate staff procedures. A system for nitoring consistent these policies could be a results of these audits being ty's Quality Assurance ew.	al s y			

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Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMPI	
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		00085	B. WING		08/2	6/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	STREET MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 965	Continued From pa	ge 10	2 965			
2 965	MN Rule 4658.0600 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			10/5/21
	must ensure that a which supplies the determined by the dassessment. Substitute by the dassessment of the da	anal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food				
	by: Based on interview facility failed to act the registered dietit	and document review, the when recommendations from ian were identified but not of 1 residents (R35) with		Correction Order #2965 Corrected Date: October 5, 2021 It is the current policy and procedu GSS-Windom to monitor resident R35 was re-assessed and their ca	weights. are plan	
	diagnoses of major dementia, anxiety and R35's quarterly Min assessment dated cognitively intact, havision, clear speech understood and courequired supervision weight gain of 5% cor more in last 6 more R35's physician or demential and coured supervision weight gain of 5% cor more in last 6 more R35's physician or demential and supervision weight gain of 5% cor more in last 6 more R35's physician or demential and supervision weight gain of 5% corrections.	inted on 8/26/21, included depressive disorder, and high blood pressure. imum Data Set (MDS) 7/23/21, indicated R35 was ad adequate hearing and an, was able to make selfuld understand others. R35 n of one eating, and had a primore in last month or 10% bonths. ders dated 6/26/21, included effects of antidepressant,		updated regarding weight gain by Dietician and Director of Food and Nutrition on Aug. 25, 2021. All residents are at potential risk for deficient practice. A weight gain a conducted the Dietician and the Diversing on Sept. 29, 2021, with the plans of any additional residents weight gain addressed. To prevent further potential deficient practice, the case managers will be re-educated and will complete a point of the potential deficient practice, the case managers will be re-educated and will complete a point of the potential deficient practice, the case managers will be re-educated and will complete a point of the potential deficient practice, the case managers will be re-educated and will complete a point of the potential deficient practice, the case managers will be re-educated and will complete a point of the potential deficient practice, the case managers will be re-educated and will complete a point of the potential deficient practice, the case managers will be re-educated and will complete a point of the potential deficient practice, the case managers will be re-educated and will complete a point of the potential deficient practice, the case managers will be re-educated and will complete a point of the potential deficient practice.	or this audit was irector of e care with ent ee ost-quiz	

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Minnesota Department of Health

AND DUAN OF CORRECTION		` '	E CONSTRUCTION	(X3) DATE COMPI		
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GOOD S	AMARITAN SOCIETY	- WINDOM	I, MN 56101			
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2 965	Continued From pa	ae 11	2 965			
	such as changes in effects of antipsych weight gain. R35's care plan with indicated R35 had a related to overeating that R35 would expect the recommended put the review date. Interest and portion size of alternatives to overfood, adverse effect During an interview when asked if she had weight gain, R35 st. but didn't know how	weight and to monitor for otic medication such as in initiated date of 4/28/21, an unplanned weight gain g, evidenced by weight gain; ress satisfaction with following portion size of snacks through erventions included talking to about healthier snack options snacks; coping behaviors, reating, feelings related to ts of weight gain. on 8/23/21, at 2:45 p.m., and experienced weight loss of ated she had gained weight, much. When asked if she but that, she stated, "well, I		GSS policy and procedure. An audit of weights in relation to w gains and ensuring appropriate for will be conducted by the QAPI Cor or designee will occur 1 time week weeks with the care planning sche Audit results will be reviewed by the committee with appropriate followinitiated to ensure solutions are sufficient.	llow-up ordinator kly for 12 edule. ne QAPI -up	
	weight gain in six m 2/24/21, to 163 pour Nutritional status prand written by regis indicated R35 was chewing or swallow feed herself. R35's showing a gradual a since admission in a significant weight gathe past six months (considered obese) assessment) score nutritional assessmerecommended talki	eights indicated a 12.41% nonths, from 145 pounds on nds on 8/23/21. rogress note dated 4/25/21, tered dietician (RD)-G, on a regular diet, had no ing problems and was able to weight was 152 pounds, and persistent weight gain April 2020, and now a ain of 18 pounds (13.4%) in a R35's BMI was up to 31.8 and (mini nutritional was 13, indicating normal ent. The dietician note ng to her family about her ain and recommended				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	* *	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00085	B. WING		C 08/26/2021	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM 705 SIXTH WINDOM,	STREET MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	decreasing calorie is smaller portions in a specific lower calor could include no brown is a sandwich, sma smaller portions of choices between mandering free beverage. R35's diet card was choices on the card large and medium was recommendations between moted on the commendations of the commendation of the commendation of the commendation of the commendation of all nerecommendation of all nerecommendations on the commendation of the commendat	ntake, either by providing general, or by starting some ie interventions. Interventions ad at meals unless the menuller portions of potatoes, desserts, lower calorie snack eals and making sure to offer ges between meals. The reviewed. Serving size at were small, medium and was checked. No by the dietician from 4/25/21, at 9:24 and her care conference notes at stated "I supposed you're commendations were acted weight gains as closely. I give writing to the DON and be able to look at those to see at through." on 8/25/21, at 9:36 a.m., DS)-E located two sets of at 4/5/21, and 4/28/21, adding a resident nutrition status twice ments were titled Medical by Consultant Dietician, and with columns for residents of the columns for cessary staff. RD-G's were hand-written. R35 was adocument. DS-E stated she my recommendations for R35	2 965			
	On 8/25/21, at 10:2	8 a.m. RD-G called back and				

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	SAMARITAN SOCIETY	- WINDOM	TH STREET M, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 965	stated she had bee would have sent the email about R35's verecommendations. During an interview DON did not recall regarding R35. The emails and stated segarding R35 from any recommendation 4/25/21, had not be nursing and therefor During an interview stated she spoke to would like smaller power want to gain any metrying smaller portion. During an interview DON had not been until 8/25, adding the should have been for significant weight graph and to the Derecommendations of the diet card and restated that process could not explain weight graph and to the Derecommendations of the diet card and restated that process could not explain weight graph and to the Derecommendations of the diet card and restated that process could not explain weight graph and to the Derecommendations of the diet card and restated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and resident nutrition stated that process could not explain weight graph and	n working remotely in April so e director of nursing (DON) are weight gain and 8/25/21, at 10:50 a.m., the receiving an email from RD-G. DON looked back in her she did not have an email the RD-G. The DON stated ons by RD-G for R35 from en communicated to dietary one had not been implemented as (25/21, at 10:56 a.m., DS-E or R35 and R35 stated she portions and agreed she didn't one weight, and would be okayons at meal times. on 8/26/21, at 11:32 a.m., the aware of R35's weight gain not RD-G's recommendations ollowed through when R35's ain had been identified in April for this was the dietician of pooling of the carried out; e.g., added to esident's care plan. The DON did not happen this time and	or ·			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED		
		00085		B. WING		08/2) 6/2021
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- WINDOM	705 SIXTI WINDOM,	NN 56101			
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2 965	Continued From particles dietician reviewed report and a each visit. SUGGESTED MET director of nursing (could review and report and	ecommendations HOD OF CORR DON) or register vise policies and assessment, more dietary recomment DON or designed nsure compliancy y assurance com	ECTION: The cred dietician of procedures nitoring and endations and endations and endations and report endittee.	2 965			
21325	MN Rule 4658.0728 Emergency Oral He Subpart 1. Routine home must provide resource, routine de needs of each resic include dental exan fillings and crowns, oral surgery, bridge orthodontic procedu that are provided fo community at large reimbursement poli This MN Requireme by: Based on observati review, the facility for recommendations wa appointments coord service for 1 of 1 re dental care.	ealth Ser e dental services e, or obtain from ental services to lent. Routine de ninations and cle root canals, peri s and removable ures, and adjunct r similar dental p , as limited by thi cies. ent is not met as on, interview, an ailed to ensure d were acted upon linated to ensure	. A nursing an outside meet the ntal services anings, odontal care, e dentures, tive services eatients in the rd party s evidenced d document ental and future e timely	21325	Correction Order #21325 Corrected Date: October 5, 2021 It is the current policy and procede GSS-Windom to follow-up on den referrals in a timely manner.		10/5/21

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STATEMEN	ITA DEPARTMENT OF HE IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SI		` ′	E CONSTRUCTION	(X3) DATE S	
, IIID I LAN	S. SOLUTEOTION	IDENTIFICATION	C.T.TOMBET.	A. BUILDING:		C	
		00085		B. WING			6/2021
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		STREET MN 56101			
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21325	Continued From partial of the partia	ge 15 Inted 8/24/21, in ason's Disease order that affect abolic disorder in levels for prolemange Minimum dated 7/9/21, in itive impairment dequate vision, elf understood at The MDS furthe cluding broken dentures (chippe) or obvious on the control of the model of	ncluded (progressive ts movement) n which the onged periods Data Set ndicated R30 at, minimal clear speech, and could her identified no or loosely ed, cracked, r likely cavity or n revised date set of care 10/21, and plastic n of dental on on 8/23/21, broken teeth ull denture on set of dentures oved and hen added	21325		duled ent Director viewed referrals ent be ost-quiz 5, 2021, bllow-up ucted by 1x vill be vith	
	but was told they we A clinic referral form had attended a rout day. Progress notes	ere "full up." n dated 2/17/21 ine dental appo	, indicated R30 pintment that				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00005			C 08/26/2021	
		00085			08/2	6/2021
	PROVIDER OR SUPPLIER	705 SIXTE		STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21325	Continued From pa	ge 16	21325			
	a filling. Notes indicoral surgery for extraction partial denture. Las make an appointment R30's quarterly ora 4/6/21, indicated R3 and full upper dentuappointment. A copy of an electro oral surgery indicat (tooth removal) of the surgery for extraction or extraction.	nad an initial exam, xrays and cated a referral was made to raction of tooth #20; and , teeth would be added to his tly, the facility was to call to ent after the extraction. I/dental assessment dated 30 had a partial lower bridge are and had a pending [dental] onic note dated 4/14/21, from ed R30 had an odentectomy ooth #20, and follow up d to continue local dentist				
	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					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
				A. BOILDING.			,
		00085		B. WING			26/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		NN 56101			
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21325	Continued From para folder and stated appointment sched titled: Appointment completed by RN-Adaughter requested as possible. The for a hand-written not at 4th." AR-F stated Fhis eye appointment dentist, but then R3 appointment AR-F had not been dental appointment AR-F had not been dental instructions make another appointment AR-F had not been dental instructions make another appointment AR-F had just mad R30. "It seems it shooner." When ask to act upon follow-the DON stated nur AR-F know to make not sure what happ was dropped. The completed the Appointment should following the dentise the dentise than that appointment should following the dentise the dentise than the dentise th	no, he did not uled. AR-F properties and Ride Recard after the en canceled a stated after the en canceled a stated after the en canceled a stated after the en canceled aware that Frindicated the bintment after tooth was extend and have been and the end who review a death of the appointment and the end recard appointment a	resented a form quest Intake, ated resident and pointment as soon ated. There was a "Eyes 1st Aug of wait till until after to go to the his eye the eye of a scheduled. The scheduled the schedu	21325			

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				71. BOILDING.			
		00085		B. WING			26/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	705 SIXTH WINDOM,	STREET MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21325	No facility policy wa appointments for re SUGGESTED MET The director of nurs develop, review, an procedures to ensu follow up dental car accordance with ind designee could edu DON or designee of systems to ensure of report those results committee for further TIME PERIOD FOR (21) days.	s provided on misidents. HODS OF CORsing (DON) or ded /or revise policing re dental care see is provided to dividual needs. It is appropriould develop moongoing compliate to the quality as er recommendate a CORRECTION	RRECTION: esignee could bies and ervices and all residents in The DON or iate staff. The ponitoring ance and esurance tions. N: Twenty-one	21325			10/9/21
21375	MN Rule 4658.0800 Program Subpart 1. Infection home must establistic control program destantiary environment This MN Requirement by: Based on observation review, the facility famous for Disease appropriately impless the spread of COVI ensure personal profincluding mask wor facility failed to separt from vaccinated research.	on control progra th and maintain a signed to provide nt. ent is not met as on, interview and ailed to follow Co caid Services (Co e Control (CDC) menting measur D-19 when the footective equipment or correctly, and arate an unvacci	m. A nursing an infection e a safe and see evidenced document enters for EMS) and guidelines by es to prevent acility failed to ent (PPE) when the inated resident	21375	Correction Order #21375 Corrected Date: October 8, 2021 On Aug. 24, 2021, R46 was place personal table, 6 feet away from cresidents, but facing them. This arrangement continues. Staff on the time of the incident were immere-educated by the Activity Director the Director of Nursing.	other duty at ediately	10/8/21

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7. BOILDING		С
		00085	B. WING	08/26/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINDOM 705 SIXTH WINDOM,	ISTREET MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
21375	Continued From pa	ge 19	21375		
	the potential to affe in the facility.	ct all 60 residents who resided		No other residents at the time of s were unvaccinated. One short-ter is currently unvaccinated and their	m client
	Findings include:			situation follows appropriate guide	lines.
	Unvaccinated Resid	dent		All staff present on Aug. 23, 2021, immediately re-educated regarding	
	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.			mask use and were provided with different style mask if needed to e proper fit.	a
				Any new unvaccinated residents v at risk for this deficient practice. A upon admission are assessed for vaccination status and will dine in accordance with GSS policy and procedure aligning with current statederal guidelines.	All clients
	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.			All residents would be at risk for s wearing/using masks appropriatel Root Cause Analysis was conduct Sept. 22, 2021, by the QAPI commincluding the Infection Preventioni was reviewed and approved by the Samaritan Society Nursing and CI Services Consultant and the Good Samaritan Society Quality Improve Advisor.	y. A ed on nittee, st and e Good inical
	(RN)-I stated there north side who had Covid-19 and that v was eating breakfa station dining room	on 8/24/21, at 8:52 a.m. was only one resident on the not been vaccinated for vas R46. RN-I confirmed R46 st at a table in the nurses with R25 and R30. When of for an unvaccinated resident		All policies and procedures for PP during the COVID-19 pandemic, in source control masks, proper use gowns, and transmission-based precautions, were reviewed and for be appropriate. To prevent further potential deficie	ncluding of ound to
		imity to other residents, RN-I wthat's what we've always		practice of unvaccinated resident all staff were re-educated Oct. 4-8 through learning boards and a pos	dining, , 2021,

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						
	IT OF DEFICIENCIES OF CORRECTION		SUPPLIER/CLIA ION NUMBER:		E CONSTRUCTION	(X3) DATE S	
VIAD L PVIA	OI JOHNLOTION	IDENTII IOAT	IOI VINOIVIDEI I.	A. BUILDING:		CONIFL	
						С	
		00085		B. WING			6/2021
		00000		<u>I</u>		00/2	3/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COOD C	AMADITAN COCIETY	WINDOM	705 SIXTI	STREET			
GOOD S	AMARITAN SOCIETY	- WINDOW	WINDOM,	MN 56101			
(X4) ID	SUMMARY STA	TEMENT OF DEFIC	IENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY			PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING IN	FORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
					DEFICIENCY)		
21375	Continued From pa	ae 20		21375			
21075	Continued From pa	ge 20		21073			
					developed by the Administrator, Di	irector of	
	During an interview	on 8/24/21, at	11:37 a.m., the		Nursing, and a Case Manager, reg	garding	
	DON was asked wh				the current requirements for unvac		
	resident, R46, ate h	er meals. The	DON stated		resident dining.		
	she was aware of C				To prevent further potential deficie	nt	
	unvaccinated reside				practice of mask wearing, all empl		
	from vaccinated res				were re-educated through lecture,		
	stated R46 was in a				demonstration, and competency to		
	room and going to t				by the Clinical Learning and Devel		
	accommodatenee				Specialist on Sept. 28-30, 2021, re		
	picturelikes to eat				standard infection control practices		
	stay long." The DO				including transmission-based pred		
	team about other of		ould talk to Hei		appropriate PPE use, and donning		
	team about other of	Juons.				anu	
	During on chaoryot	ion on 9/24/21	ot 10:54 n m		doffing PPE.	مط النبير مر	
	During an observat				Residents and their representative		
	observed R46 eating				educated via email/postal mail/roo		
	nurses station dinin				delivery on Oct. 1, 2021, and in pe		
	from a table with Ra				Oct. 6, 2021, at the Resident Cour	icii by	
	been set up for R46				the Administrator and Infection		
	with her name on it				Preventionist regarding the facility		
	was not isolated an		to see and		infection control program, including	g visitor	
	hear other residents	s and staff.			responsibilities.		
		0 11100 ::					
	Facility policy titled				Any unvaccinated resident dining		
	Long-term Care Inc		•		situations will be randomly audited	,	
	facilities and Assist				QAPI Coordinator or designee, 3 t		
	the State departme		·		per week at various meals for 4 we		
	indicated if unvacci				then 1 time per week for 8 weeks.		
	during communal d				The QAPI Coordinator and design		
	residents should us				audit in the following manner. A m		
	eating, and unvacci		s should		of 10 times per week for 4 weeks,		
	physically distance	from others			times per week for 8 weeks or unt		
					compliance is sustained; covering		
	Mask Observations				shifts and multiple departments. F		
					audited will include, employees, vi	sitors,	
	On 8/23/21, the following	owing mask ob	servations		and residents. Items to be audited	t	
	were made: of staff				include, but are not limited to: dor	nning	
	were not appropriat				and doffing of PPE with	-	
	At 1:42 p.m., admir				transmission-based precautions,		
	was observed with				aerosolized generating procedures	s to	

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					c	;
		00085	B. WING		08/2	6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
	observed with mask At 2:31 p.m., nursin observed with mask At 3:19 p.m., DON wear mask below n At 3:30 p.m., registe observed with mask At 3:30 p.m., mainte with mask below no At 5:45 p.m., (NA)-E below nose. At 5:50 p.m., While activities (A)-B beno	g assistant (NA)-D was below nose. was observed to continue to ose. ered nurse (RN)-J was below nose. enance (M)-A was observed ose. was observed with mask in R47's room, observed deforward at the waist, directly		ensure PPE is used, and proper upper gowns. All audit results will be reviewed by QAPI committee with appropriate follow-up initiated to ensure solution sustained.	y the	
	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.					
	director of nursing (asked what the exp masks, was it okay nose. The DON sta it was not the corr infection control pur masks did not stay manipulated it while stated they would lo					
	observed DON with mask on. The mask	ion on 8/23/21, at 7:01 p.m., a different style surgical c was observed to be yellow, stated they found some				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				A. BOILDING.	·		c
		00085		B. WING			26/2021
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		H STREET MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 22		21375			
	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.						
	DON (Director of N monitor to assure p the potential spread designee could mo wearing appropriate recommended by 0 to prevent the spreadesignee could edu to ensure the polici results of these aud	THOD OF CORRECTI ursing) or designee coroper PPE is worn to perform to ensure staff at the PPE during care and EMS, CDC and State and of COVID-19. The acate staff and performes are being followed. State could be reviewed to ensure	ould orevent ON or re I as Agency DON or audits The				
	Time Period for Co days.	rrection: Twenty-one (21)				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients ac.Bill of Rights	&	21805			10/8/21
		us treatment. Patients					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLET	
			A. BOILDING	·	С	
		00085	B. WING		08/26/	2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET , MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 23	21805			
	courtesy and respe	ct for their individuality by rsons providing service in a				
	by:	ent is not met as evidenced				
	Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 1 of 1 residents (R29) who were			Correction Order #21805 Corrected Date: October 8, 2021		
	required assistance with activities of daily living (ADLs).			It is the current policy and procedu GSS-Windom to provide care con with resident dignity.		
	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: The pants were changed ar removed on Aug. 25, 2021. Availaded employees were re-educated immal residents are at risk for this depractice. An audit was conducted Case Manager on Oct. 1, 2021 of clothing and any additional clothin	able nediately. ficient by a resident	
	assessment dated	imum Data Set (MDS) 7/9/21, identified R29 was nd required two person		did not fit properly was removed.	ginat	
		dressing, toilet use, personal nd utilized a wheelchair for		To prevent further potential deficiency practice, all nursing staff were re-common control of the control of th	educated	
	self care performar weakness and inab	ted 1/4/21, indicated an ADL ace deficit R/T [related to] illity to independently dress, athe self and interventions		Administrator, Director of Nursing Case Manager regarding the resident to dignity, especially in regard proper fitting clothing.	dent's	
	included dressing v lower body, encour- toilet use total lift, la	with total assist of 1-2 with age participation with upper; arge sling and 2 assist to mode/toilet and total assist		At the Oct. 6 resident council mee administrator will review the right with the residents.		
	on 8/23/21, at 3:40 interviewed while se	p.m. R29 was observed and eated in a wheelchair in his were observed poor fitting.		A random audit of residents regard proper fitting clothing will be conditated the QAPI Coordinator or designed weekly for 4 weeks and then 1 times week for 8 weeks. Audit results with the property of the pr	ucted by e, 3 times ne per	

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PRINTED: 10/13/2021 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING 00085 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **705 SIXTH STREET GOOD SAMARITAN SOCIETY - WINDOM** WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21805 Continued From page 24 21805 baggy, with snaps at each side not buttoned, or reviewed by the QAPI committee with pulled up around R29's waist. R29 stated "my appropriate follow-up initiated to ensure pants are embarrassing" and further indicated he solutions are sustained. 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.

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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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00085		B. WING			C 26/2021	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WINDOM	705 SIXTI	DRESS, CITY, S H STREET , MN 56101	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED I SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21805	Continued From particles of the administrator, of the administrato	es of Daily living relicated le residents with appression of daily living for the rand soul. It who is unable to ing or receive neces a good nutrition, grygiene. If the prosthesis ing on and off the recommode; cleans and appression of all residents and appression of self worth ecting and abiding so of her individualities is self worth ecting and abiding the self worth ecting and abiding so of her individualities is self worth ecting and abiding the self worth ecting and abiding the self worth ecting and abiding the self worth expression in the self worth expression	opropriate improve ne well carry out essary ooming and utting on, ing toilet, use sing after ads; alled dated sence the their sidents and stains or respect in ty. The original of the original carries of day an hospital carries of the carries of t	21805				
	designee could dev care by the interdisc							

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		00085	B. WING		C 08/26/2021						
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE							
GOOD SAMARITAN SOCIETY - WINDOM 705 SIXTH STREET WINDOM MN 56101											
WINDOM, MN 56101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)											
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG								
21805	residents dignity is could update policie staff on these changeresident(s) dignity a these audits could be assurance committed.	ge 26 being maintained. The facility es and procedures, educate ges, and audit to ensure are maintained. The results of the reviewed by the quality ee to ensure compliance. R CORRECTION: Twenty-one									
21915	Residents of HC Far Subd. 27. Advisor their families shall it maintain, and partic family councils. Ea assistance and spa meetings shall be a visitors attending or invitation. A staff por responsibility of pro responding to writte council meetings. It shall be encouraged regarding facility por This MN Requirement by: Based on interview facility failed to atter council on at least a potential to affect al reside in the facility Findings include:	ry councils. Residents and have the right to organize, cipate in resident advisory and ch facility shall provide are for meetings. Council afforded privacy, with staff or any upon the council's erson shall be designated the eviding this assistance and en requests which result from Resident and family councils do make recommendations dicies. The providence of the providence of the entity of the providence		Correction Order #21915 Corrected Date: Sept. 21, 2021 Family Council An email/postal mail communicatio sent to families/responsible parties Sept. 21, 2021 regarding family council and the opportunity to form said council a family council is not formed at this	on uncil uncil. If						
		8/26/21, at 8:52 a.m. social SSD) confirmed the facility did									

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STATE FORM PELM11 If continuation sheet 27 of 28

PRINTED: 10/13/2021 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING 00085 08/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **705 SIXTH STREET GOOD SAMARITAN SOCIETY - WINDOM** WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21915 21915 Continued From page 27 not have an existing family council. The SSD September, 2022 to assure the facility further confirmed no attempt had been made to offers the opportunity to form said council. 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.

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