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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SJ9M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00085

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/11/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **78** (L18)
13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Gloria Derfus, Unit Supervisor — 09/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 10/03/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/25/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245558 September 27, 2017

Ms. Nancy Wepplo, Administrator
Good Samaritan Society Windom
705 Sixth Street
Windom, MN 56101

Dear Ms. Wepplo:

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 September 5, 2017 the above facility is recommended for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 27, 2017

Ms. Nancy Wepplo, Administrator
Good Samaritan Society Windom
705 Sixth Street
Windom, MN 56101

RE: Project Number S5558025

Dear Ms. Wepplo:

On August 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 27, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 20, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 27, 2017, effective September 5, 2017 and therefore remedies outlined in our letter to you dated August 10, 2017, will not be imposed.

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.

Feel free to contact me if you have questions related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SJ9M

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(L2) **677840200**

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **78** (L18)
13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HPR Dietary Specialist 9/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 10, 2017

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: Project Number S5558025

Dear Ms. Wepplo:

On July 27, 2017, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 5, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by October 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 January 27, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide engaging activities for 2 of 4 residents (R47, R67) reviewed for activities who lived on the secured unit of the facility. Findings include:	F 248	F-248 Corrected Date: Sept. 5, 2017 It is the current policy and procedure of GSS-Windom to provide all residents with activities that meet their interests and preferences.	9/5/17

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

Electronically Signed | 08/20/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 1 A review of an activity calendar for the secured unit of the facility identified the following: Monday July 24, 2017: 7:00 a.m. to 8:00 a.m. Breakfast Meal 8:30 a.m. Today's Current Events 10:30 a.m. Hymn Sing Program 11:00 a.m. Devotions and Prayers 11:15 a.m. to 12:15 p.m. Dinner Meal 1:15 p.m. Intellectual and One to One Programs 1:45 p.m. Coffee Club and Chat 3:00 p.m. Musical Talents of Lizzie Roy 5:00 p.m. Devotions and Prayers 5:15 p.m. to 6:15 p.m. Supper Meal 7:00 p.m. "At the Cinema" The activity calendars for July 25, July 26, July 27, July 28 and July 29, 2017, were identical to July 24, 2017, except the 3:00 p.m. musical program which was replace with "Physical Program" all other days. A review of the activity calendar for the non-secured units in the facility included activities such as Outside in Connie's Garden, Bowling Program, Nail Care, Word Games, Bingo, making of fleece blankets and a Spelling Bee. During an observation on 7/25/17, at 2:04 p.m. the residents on the secured unit were sitting in the dining room looking at magazines and drinking coffee. In the main dining room of the non-secured unit multiple residents were involved in a bowling game. During an observation on 7/25/17, at 3:04 p.m. activity staff sat down at a table with four residents and began to engage them in exercises	F 248	The activity assessments and care plans of R47 and R67 will be reviewed and updated by the Recreation Director to reflect their current interests and preferences by Sept. 5, 2017. Residents who reside within the unit are at risk for similar deficient practices. Their activity assessments and care plans will be reviewed and updated by the Recreation Director to reflect their current interests and preferences by Sept. 5, 2017. A new recreation calendar will be developed based on the interests and preferences of the residents on the unit by Sept. 5, 2017. All activity staff will be re-educated by the Recreation Director by Sept. 5, 2017, regarding the new unit recreation calendar, how to engage residents in activities, and how to meet resident activity interests and preferences. An audit will occur of the activity calendar by the Administrator or designee for 4 months to assure the activities are varied and meet the interests and preferences of those residing on the unit. An audit will occur of the activity programming on the unit by the Recreation Director or designee to assure residents are invited and engaged in activities of their interests and preferences, 5x/week for 4 weeks, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	07/27/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 2 using their hands and legs. No other residents were invited or encouraged to join the group by the activity aide or the nursing staff. A resident slept in a chair directly behind the activity aide. He was not encouraged to join. During an observation on 7/26/17, at 9:57 a.m. a nursing assistant (NA) on the unit was engaging two residents in the dining room in a question game. the NA did not attempt to engage the other three residents in the dining room. R47's care plan dated 2/7/17, indicated she was dependent on staff for activities, cognitive stimulation and social interaction and was unable to keep herself occupied. The care plan directed staff to encourage ongoing family involvement and offer to turn on television or music in her room when she chooses not to participate in group activities. R47's quarterly Minimum Data Set (MDS) dated 5/5/17, indicated she had intact cognition and required extensive assistance for mobility on the unit. During an observation on 7/26/17, at 9:22 a.m., R47 was sleeping in the lounge chair. A movie titled Walk the Line was playing on the television and two residents left the room while the movie was playing. During an observation on 7/26/17, at 1:25 p.m., activity aide (AA)-B was in the resident lounge area. She was finishing reading a story to three residents. Two of the residents were sleeping and R47 was awake. AA-B stated she was done reading stories for the day and said she would turn the movie back on. During an observation on 7/26/17, at 1:38 p.m.	F 248	3x/week for 4 weeks, and then monthly x2. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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	245558	A. BUILDING _____ B. WING _____	07/27/2017

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R47 was sitting in front of the television. She was watching "Walk the line," the same movie that was playing at 9:22 a.m. R47 stated, "I'm watching the movie because I have nothing else to do." She then asked the surveyor if there was something she could do.

During an observation on 7/26/17, at 2:00 p.m. three residents were sitting in the dining room drinking coffee. Bingo was in progress in another part of the building. The residents on the secured unit were not invited to play bingo off the unit, nor was bingo scheduled to be played on the unit.

During an observation on 7/27/17, at 8:40 a.m. AA-B was in the resident lounge area reading the newspaper out loud. Five residents were present in the room. R47 was sitting with her eyes closed. Another resident was sitting in a recliner, not engaged in the activity and three others were sitting with their eyes closed.

During an observation on 7/27/17, at 10:27 a.m., several residents were seated at table in the dining room. A radio was turned on playing music. Four of the residents had hymn books in front of them. One resident was attempting to leave the table, two others were sitting with their eyes closed and R47 was wheeling herself away from the table.

R67's annual MDS dated 5/5/17 indicated she was severely cognitively impaired and required supervision on and off the unit. R67's care plan dated 7/5/16 indicated she was dependent on staff for activities, cognitive stimulation and social interaction related to an inability to occupy herself. The care plan identified R67's preferred activities as courtyard strolls, looking at flowers

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and weekly worship service.

During an observation on 7/26/17, at 1:25 p.m., AA-B was in the resident lounge reading stories to 3 residents. R67 was requesting to go outside. AA-B stated she would turn on a movie for the residents in the lounge. Staff did not offer to take R65 outside.

During an observation on 7/26/17, at 2:00 p.m. Three residents were sitting in the dining room drinking coffee. Bingo was in progress in another part of the building. The residents on the secured unit were not invited to play bingo off the unit, nor was bingo scheduled to be played on their unit.

During an observation on 7/26/17, at 2:40 p.m. R67 was sitting at a table in the dining room playing with the foot pedals on her wheel chair. She had removed her foot pedals from her wheel chair and was attempting to put them back on.

During an observation on 7/27/17, at 8:40 a.m. AA-B was in the resident lounge reading from a newspaper. Five residents were sitting in the room. R47 was sitting with her eyes closed. Another resident was sitting in a recliner, not engaged in the activity and 3 others were sitting with their eyes closed. R67 was sitting in the dining room staring at the wall. There was nothing on the table in front of her.

During an observation on 7/27/17, at 10:27 a.m. four residents were seated at a table in the dining room with hymn books in front of them. Music was playing in the background. Two residents were sitting with their eyes closed and appeared to be asleep. One resident was wheeling away from the table. R65 was attempting to leave the

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table with her wheel chair brakes locked. Staff was not attempting to engage the residents in the music activity.

During an interview on 7/27/17, at 9:36 a.m., AA-B stated she goes to the secured unit three times a day. She stated in the morning she reads the current events at 11:30 a.m., she reads devotions before the meal and at 3:00 p.m. she does exercises. She stated she felt the residents involved in the current events that morning was "pretty much" listening. AA-B stated she usually has to bring her own people to activities and stated they know I'm coming and I have to be out by 9:00 a.m. She stated that morning staff had brought the residents to the lounge and she didn't think R67 had been invited. She stated the residents in the secured unit don't usually come off the unit for activities. She stated the only activities they attend off the unit are the beauty shop and if there is special entertainment. She stated "back in the day" some of the residents would leave the unit to play bingo and stated they were chosen by the case manager if they were able to play. AA-B further stated it's hard to do bingo with a table full of residents.

During an interview on 7/27/17, at 11:31 a.m. the activity director (AD) stated the recreation staff does large group programming on the secured unit. She stated the staff was usually there three times per day. She stated the activity calendar does not change, "to keep a routine." She stated during current events, the residents engage to their own level of participation. She stated they also have a 3:00 p.m. exercise group and stated the staff should be engaging as many residents as possible. The AD stated there were many residents who used to attend activities on the

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F 248	Continued From page 6 main unit but their abilities fluctuate. She stated she does not want to bring them to a large group and "have their dignity crossed by yelling and talking about fecal matter." She stated there was a closet on the unit that contained sensory objects such as balls, felt, fabrics and nursing staff should be directing those activities. The AD stated the activity on the calendar titled "at the cinema" indicated a movie was shown each night.	F 248		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and	F 280		9/5/17

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F 280	Continued From page 7 shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 280		

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F 280	Continued From page 8 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise care plan interventions to improve incontinence when a decline in the continence status was identified for 1 of 1 resident (R26) reviewed for urinary incontinence. Findings include: R26's admission Minimum Data Set (MDS) dated 3/20/17, indicated R26 was moderately cognitively impaired, continent of bladder and needed one staff's limited assistance with toilet use. The Care Area Assessment (CAA) dated 3/27/17, indicated "due to impaired cognition and impaired vision needs limited assist of one at night to use toilet. The care plan revised on 3/30/17, indicated R26 was independent with toilet use and directed staff "to setup pad use next to toilet and supervise/manage disposal of soiled pads in garbage." The care plan also indicated R26 had potential impairment to skin integrity related to occasional urinary incontinence, and R26 used pad in underwear. R26's quarterly MDS dated 6/2/17, noted R26	F 280	F-280 Corrected Date: Sept. 5, 2017 It is the current policy and procedure of GSS-Windom to provide appropriate care and services to meet the needs of all clients. A new 72-hour bladder assessment was completed for R26 with care plan updates made by Aug. 18, 2017. Residents, who have gone from continent to occasionally incontinent coding on the MDS, are at risk for similar deficient practices. They will be audited to assure a new 72-hour bladder assessment was completed and the care plan was updated appropriately by Sept. 5, 2017. All MDS nurses will be re-educated by the Director of Nursing on Aug. 29, 2017 regarding bladder assessments and MDS coding. Section H of the MDS for all residents will	

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F 280	Continued From page 9 was moderately cognitively impaired, occasionally incontinent of bladder (less than 7 episodes of incontinence during 7 day look back period), and needed one staff's extensive assistance for toilet use. There was no additional assessment, or plan developed to help improve R26's urinary incontinent status, once a decline with urinary status was identified. On 7/26/17, at 8:27 a.m. R26 was observed sitting in the recliner in the room, and there were no signs or symptoms of urinary incontinence noted. During interview at this time R26 stated she was independent with toileting needs, and staff didn't help at all. R26 also stated she wore a pad in her underwear, and was changing it herself when it got damp. R26 also related she had impaired vision, but was able to find items in the bathroom. R26 also stated she probably got wet once daily, and pads were kept in the dresser in the closet. On 7/26/17, at 1:32 p.m. nursing assistant (NA)-A was interviewed and stated they provided cares to the residents based on the care plan identified on the Kardex. NA-A also stated R26 was independent with toileting needs, and probably was wet once a day. NA-A explained staff would know about the incontinence since R26 would leave her wet pants, and pad in the bathroom for staff to remove. NA-a also stated staff set out the pads for R26, and helped when she called for help. On 7/26/17, at 2:17 p.m. the registered nurse (RN)-A (also nurse manager) was interviewed. RN-A stated residents bladder status was assessed upon admission, and with change in urinary continence status. RN-A stated she	F 280	be audited by the Director of Nursing or designee for changes in continence compared to the prior MDS. With any changes, the Director of Nursing or designee will assure that the 72-hour bladder assessment was completed and that current care plans reflect the assessment. Residents will be audited during their quarterly/annual MDS assessment cycle until all residents have been audited 1x (3 month cycle). Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 280	Continued From page 10 completed R26's MDS's, and coded R26 was continent of bladder upon admission and occasionally incontinent of bladder with the quarterly MDS dated 6/2/17. RN-A acknowledged that there was a decline in R26's urinary continence status, R26 should have been reassessed, and new interventions developed such as bladder retraining program. On 7/27/17, at 9:12 a.m. the facility's director of nursing (DON) was interviewed and stated staff were expected to reassess residents when a decline in urinary continence status was identified, by initiating the 72 Hour Bowel and Bladder Monitoring, and based on that completing the Bladder Assessment to determine type of urinary incontinence and initiating a bladder retraining program plan. DON stated no re-assessment of R26's bladder incontinence had been completed. The facility's Bowel and Bladder Assessment Evaluation and Retraining policy dated revised on 5/16, indicated "Every new resident will be observed for 72 hours for bladder and bowel incontinence and then evaluated for feasibility in retraining for bladder and bowel control. When significant change affecting elimination occurs (i.e., decline or improvement), the resident will be re-evaluated. "	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 282		9/5/17

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F 282	Continued From page 11 (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care planned interventions to reduce the risk for falls for 1 of 3 residents (R93) reviewed for accidents. Findings include: R93's Annual Minimum Data Set (MDS) dated 4/5/27 indicated she was severely cognitively impaired, required extensive assistance from two staff for toileting and transfers, and was frequently incontinent of bowel and bladder. A Care Area Assessment (CAA) dated 4/10/17 identified a fall since admission and indicated the use of an alarm. The CAA indicated R93 would pick the alarm up with when making unsafe transfers. The CAA further indicated R93 was at risk for further falls due to her dementia. R93's care plan dated 3/30/17 indicated a self-care deficit related to dementia and an inability to perform activities of daily living independently. The care plan directed staff to assist with ambulation, toilet use and transfers. The care plan further identified a risk for falls exhibited by a history of falls. Care planned interventions included: ensure proper foot wear is worn, bed alarm, check every 15 minutes while in bed, do not leave her alone and a rocker chair and mechanical cat on her lap. A review of facility untitled incident reports dated 3/30/17 - 7/4/17 identified R93 had sustained eight falls since admission to the facility.	F 282	F-282 Corrected Date: Sept. 5, 2017 It is the current policy and procedure of GSS-Windom to provide appropriate care plan interventions to reduce the risk of falls. R93□s care plan was updated to reflect current interventions to reduce the risk of falls by Aug. 8, 2017. A new fall risk assessment was completed with appropriate interventions initiated. R93 has not had a fall since July 4, 2017. Anyone with more than 1 fall in the last 3 months will have their falls assessment and care plan audited to assure interventions are appropriate and carried out by Sept. 5, 2017. All nursing staff will be re-educated by the Director of Nursing by Sept. 5, 2017, regarding care plan interventions for falls. An audit of anyone with more than 1 fall in the next 3 months will be conducted by the Director of Nursing or designee to ensure appropriate care plan fall interventions are in place and followed. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 282	Continued From page 12 During an observation on 7/25/17, at 2:04 p.m. R93 was lying in bed. Her eyes were open and she was moving around in the bed. At 2:35 p.m. R93 continued to lay in bed wide awake. At 2:51 p.m. she remained in bed awake. During an observation on 7/26/17, at 7:13 a.m. R93 was in bed. At 7:27 a.m., she remained in bed, no staff had checked on her. At 7:37 a.m. staff had still not checked on R93. R93 remained in her room in bed until 8:21 a.m. then staff entered the room to check on her, a total of 44 minutes even though the care plan directed staff to check on her every 15 minutes while in bed. During an interview on 7/26/17 at 1:42 p.m. nursing assistant (NA)-C stated R93 had not had too many falls that she could think of. She stated R93 used to try to crawl out of bed or stand out of her chair, NA-C stated R93 had a new wheel chair that reclines so she could sleep in it. During an interview on 7/27/17, at 9:22 a.m. registered nurse (RN)-C stated R93 had a history of falls from the previous facility. RN-C stated she had a personal alarm and stated the nurses should be documenting when it goes off to attempt to determine a pattern but was not sure if anything had been documented. She stated R93 had been removing the alarm from her chair so a different type of alarm was initiated. RN-C stated the staff performed frequent checks on R93. During an interview on 7/27/17, at 10:52 a.m. the director of nursing stated she expected staff to follow the plan of care. She stated if the care plan directed staff to check on R93 every 15 minutes, staff should do that.	F 282		

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F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 309	F-309	9/5/17

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F 309	Continued From page 14 review, the facility failed to ensure ongoing assessment was conducted to identify new areas of skin breakdown or changes and/or deterioration in current skin breakdown for 1 of 1 resident (R74) reviewed for non pressure related skin issues. Findings include: R74's quarterly Minimum Data Set assessment dated 5/12/17, indicated he was moderately cognitively impaired and required extensive assist with all activities of daily living (ADL's). The Care Area Assessment (CAA) dated 2/20/17 indicated R74 was at risk for pressure ulcer development due to weakness and incontinence. R74's care plan dated 3/8/17, indicated potential for pressure ulcer development due to decreased mobility and incontinence of bowel and bladder and potential impairment to skin integrity due to vascular ulcers, recurrent red buttocks from refusing toileting and history of rash on extremities. The care plan directed staff to monitor location, size and treatment of open area, report abnormalities and to conduct weekly skin observation by licensed nurse. Review of a facility Nursing Documentation worksheet dated 5/9/17, identified the third toe on the left foot had a small open area on the top. Review of Nursing Documentation worksheets dated 6/14/17 and 7/18/17, identified no abnormal skin conditions. A review of facility nursing Progress Notes identified on: 5/1/17 a blood area on buttocks right side and skin had ripples from pressure on buttocks. 5/17/17 "trousers were saturated with urine down	F 309	Corrected Date: Sept. 5, 2017 It is the current policy and procedure of GSS-Windom to provide on-going skin assessments to identify and care for non-pressure related skin issues. The weekly skin observation assessment will be conducted and updated to identify new areas of skin breakdown or changes in current skin breakdown for R74 by Aug. 19, 2017. R74□s care plan will subsequently be updated to reflect his current condition by Aug 19, 2017. He will remain on the weekly skin observation list on-going or until a condition change takes place that would indicate removal from the list. All residents with moisture associated skin damage (MASD) or potential for MASD are at risk for similar deficient practices. Section M of the MDS will assist in identifying those potentially at risk. Skin observation assessments and care plan updates will be conducted by Aug. 31, 2017. They will be put on the weekly skin observation list as appropriate. All nursing staff will be re-educated by the Director of Nursing by Sept. 5, 2017 regarding skin assessments, MASD, and interventions. An audit of Section M of the MDS will be conducted by the Director of Nursing or designee, to identify those as risk of MASD and to discern if their interventions and care plans are appropriate.	

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	245558	A. BUILDING _____ B. WING _____	07/27/2017

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F 309	Continued From page 15 to wet socks (had no brief on). Peri care done, found 2 open areas on crease of R [right] buttocks, size 1 cm [centimeter] each. Barrier cream applied. Was incontinent of small amt [amount] of stool as well." 5/25/17 Skin intact at present. Has history of vascular ulcers and red buttocks from MASD (moisture associated skin damage). There was no monitoring documentation regarding the open areas located on buttocks which was first identified on 5/17/17 according to the nursing progress notes. During an interview on 7/26/17, at 1:33 p.m. the 5/17/17 nursing progress note which contained the two open areas on buttocks was brought to RN-B's attention, RN-B stated she was unaware there was a sore there and that she would have expected monitoring documentation "of any wound." During observation on 7/26/17, at 1:58 p.m. with RN-B, a slit approximately 1 to 2 inches in length and reddened area was observed in the crease of the buttocks. RN-B stated, "his skin is fragile." During an interview on 7/26/17, at 2:45 p.m. RN-B stated she would have expected the open areas noted in the 5/17/17 progress note to have been communicated in report and that a weekly skin inspections by the night nurses had been completed. During an interview on 7/27/17 at 11:32 a.m. the director of nursing (DON) stated the night nurse is in charge of conducting weekly skin inspections and they have a schedule of who needs the routine inspection. "I would think he [R74] is on	F 309	Residents will be audited during their quarterly/annual MDS assessment cycle until all residents have been audited 1x (3 month cycle). Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 309	Continued From page 16 that routine schedule." The DON further stated the nurse who completed the skin inspection in May should have passed the information regarding the two open areas on buttocks having had reported and develop appropriate plans should have been made, "I would have expected it to be followed up on [in regards to the two open areas on buttocks healing]." Following inquiry by the surveyor, a nursing progress note dated 7/26/17 identified redness between gluteal folds during toileting and after cleansing with a moist cloth a superficial slit approximately 3 centimeters long was noted. Barrier cream was applied. The progress note identified R74 has recurrent moisture associated skin damage (MASD) areas as is incontinent of bladder and frequently of bowel. A facility policy titled Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements, with revision date 4/16, indicated staff were to systematically assess residents with regard to risk of skin breakdown and accurately document observations and assessments of residents. The policy further indicated if the skin issue was a bruise/contusion/skin tear/abrasion it should be monitored weekly and any changes should be documented in the care plan. If a pressure ulcer is present, daily monitoring should be completed.	F 309		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain	F 315		9/5/17

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F 315	Continued From page 17 continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to re-assess and develop interventions to improve continence following an identified decline in the continence for 1 of 1 resident (R26) reviewed for urinary incontinence.	F 315	F-315 Corrected Date: Sept. 5, 2017 It is the current policy and procedure of GSS-Windom to provide appropriate care and services to meet the needs of all	

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F 315	Continued From page 18 Findings include: R26's admission Minimum Data Set (MDS) dated 3/20/17, indicated R26 was moderately cognitively impaired, continent of bladder and required limited assist from one staff for toilet use. The Care Area Assessment (CAA) dated 3/27/17, indicated "due to impaired cognition and impaired vision needs limited assist of one at night to use toilet." The care plan revised on 3/30/17, indicated R26 was independent with toilet use and directed staff "to setup pad use next to toilet and supervise/manage disposal of soiled pads in garbage." The care plan further indicated R26 had potential impairment to skin integrity related to occasional urinary incontinence, and used pad in underwear. R26's quarterly MDS dated 6/2/17, noted R26 was moderately cognitively impaired, occasionally incontinent of bladder (less than 7 episodes of incontinence during 7-day look back period), and needed one staff's extensive assistance for toilet use. There was no additional assessment, or care plan interventions developed to help improve R26's urinary incontinent status, once a decline with urinary status was identified. On 7/26/17, at 8:27 a.m. R26 was observed sitting in the recliner in the room, and there were no signs or symptoms of urinary incontinence noted. During interview at this time R26 stated she was independent with toileting needs, and staff didn't help at all. R26 also stated she wore a pad in her underwear, and was changing it herself when it got damp. R26 also related she had impaired vision, but was able to find items in the bathroom. R26 also stated she probably got wet once daily, and pads were kept in the dresser	F 315	clients. A new 72-hour bladder assessment was completed for R26 with care plan updates made by Aug. 18, 2017. Residents, who have gone from continent to occasionally incontinent coding on the MDS, are at risk for similar deficient practices. They will be audited to assure a new 72-hour bladder assessment was completed and the care plan was updated appropriately by Sept. 5, 2017. All MDS nurses will be re-educated by the Director of Nursing on Aug. 29, 2017 regarding bladder assessments and MDS coding. Section H of the MDS for all residents will be audited by the Director of Nursing or designee for changes in bladder continence compared to the prior MDS. With any changes, the Director of Nursing or designee will assure that the 72-hour bladder assessment was completed and that current care plans reflect the assessment. Residents will be audited during their quarterly/annual MDS assessment cycle until all residents have been audited 1x (3 month cycle). Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 315	Continued From page 19 in the closet. On 7/26/17, at 1:32 p.m. nursing assistant (NA)-A was interviewed and stated cares were provided based on the care plan identified on the Kardex. NA-A stated R26 was independent with toileting needs, and was wet once a day. NA-A explained staff would know about the incontinence since R26 would leave her wet pants and pad in the bathroom for staff to remove. NA-A further stated staff set out the pads for R26, and helped when she called for help. On 7/26/17, at 2:17 p.m. registered nurse (RN)-A was interviewed. RN-A stated resident's bladder status was assessed upon admission, and with change in urinary continence status. RN-A stated she completed R26's MDS's, and coded R26 was continent of bladder upon admission and occasionally incontinent of bladder with the quarterly MDS dated 6/2/17. RN-A acknowledged that there was a decline in R26's urinary continence status, R26 should have been reassessed, and new interventions developed such as bladder retraining program. On 7/27/17, at 9:12 a.m. the facility's director of nursing (DON) was interviewed and stated staff were expected to reassess residents when a decline in urinary continence status was identified. She stated a 72 Hour Bowel and Bladder Monitoring tool along with a Bladder Assessment was used to determine type of urinary incontinence and initiation of a bladder retraining program plan. The DON stated no re-assessment of R26's bladder incontinence had been completed. The facility's Bowel and Bladder Assessment	F 315		

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F 315	Continued From page 20 Evaluation and Retraining policy dated revised on 5/16, indicated "Every new resident will be observed for 72 hours for bladder and bowel incontinence and then evaluated for feasibility in retraining for bladder and bowel control. When significant change affecting elimination occurs (i.e., decline or improvement), the resident will be re-evaluated."	F 315		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		9/5/17

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F 323	Continued From page 21 Based on observation, interview and document review, the facility failed to perform a root cause analysis in an effort to reduce falls for 2 of 3 residents (R69, R93) reviewed for falls. In addition, the facility failed to implement a system to ensure toilet safety frames were maintained in a safe manner for 19 of 21 residents (R6, R13, R14, R16, R24, R25, R26, R27, R29, R32, R38, R45, R50, R56, R61, R65, R73, R74, R79) reviewed for loose toilet safety frames. Findings include: R69's admission Minimum Data Set dated 5/9/17, indicated he was severely cognitively impaired, required extensive assist of one for transfers and was unsteady when moving from a seated to standing position and transfer between bed and chair or wheelchair. A Care Area Assessment (CAA) dated 5/9/17, identified a potential for falls with difficulty maintaining sitting balance and impaired balance during transitions with one fall since admission without injury. The care plan dated 5/15/17, indicated R69 had an actual fall with no injury related to decreased mobility, cognitive deficits and impaired safety awareness. The care plan directed staff to ensure that resident was wearing gripper sox, did not wear shoes, checked with resident as staff passes by and ask him if he needs anything, have anti-tip bars, grab bar on bed, checked every 15 minutes, assist to toilet after returning from activity, toilet at 4:00 a.m., use bed alarm and stay at desk when resident was in blue chair by desk. During an observation on 7/26/17, at 9:19 a.m., R69's bed alarm sounded. Staff entered R69's room to find he had self transferred to his wheel chair. R69 was wearing gripper socks and	F 323	F-323 Corrected Date: Sept. 5, 2017 It is the current policy and procedure of GSS-Windom to provide an environment free from accident hazards. A root cause analysis was completed via the Fall Scene Huddle Worksheet for R69 and R93 on Aug. 8, 2017. Fall risk assessments and care plans were updated as appropriate. R69 recently began a restorative nursing program and has become financially eligible for skilled therapy, which is also being pursued. R93 has not had a fall since July 4, 2017. Anyone with more than 1 fall in the last 3 months will have a root cause analysis completed of their falls with the care plan audited to assure interventions are appropriate and carried out by Sept. 5, 2017. All nursing staff will be re-educated by the Director of Nursing by Sept. 5, 2017, regarding root analysis for falls. An audit of anyone with more than 1 fall in the next 3 months will be conducted by the Director of Nursing or designee, to ensure root cause analysis was completed along with appropriate care plan updates and interventions. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated. Toilet safety frames for R6, R13, R14,	

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F 323	Continued From page 22 propelled himself into the dining room. At 9:22 a.m. staff brought coffee and animal crackers to him. During an observation on 7/26/17, at 12:51 p.m., R69 observed in bed asleep. At 12:56 p.m., R69's bed alarm sounded. Nursing assistant (NA)-C entered his room and advised him to stay in bed because the floor was wet from housekeeping cleaning the floors. At 12:59 p.m., R69's bed alarm sounded again. NA-C went in and continued to advise resident to lay back down in his bed because the floor was still wet. R69 laid back down. At 1:02 p.m., R69's bed alarm sounded for a third time. When NA-C entered the room, R69 was sitting up in bed. Staff assisted him to the wheelchair and escorted him to the dining room. At 1:07 p.m., R69 stood up from his wheel chair and grabbed a snack from a nearby cabinet. No staff were present in the dining room. Activity aide (AA)-B entered the dining room, she locked R69's wheel chair brakes and asked him sit down in wheelchair. At 7/26/17, at 1:24 p.m., R69 was in bed when his alarm sounded. At 1:30 p.m. staff assisted into a chair next to the nurses station by registered nurse (RN)-C. At 1:37 p.m., R69 was observed on the floor laying on his left side next to the chair. RN-C asked R69 if he was trying to get up by himself, R69 stated he was. At 1:43 p.m., when R69 was asked what happened he stated he did not know where he was going. A review of R69's Incident Reports and Fall Scene Huddle Worksheets dated 5/12/17 to 7/26/17 identified the following falls: -5/12/17, at 1:40 p.m., the Incident Report indicated a visitor found R69 on the floor laying on his right side in front of the dresser, in his room. Resident stated he was sitting in his chair	F 323	R16, R24, R25, R26, R27, R29, R32, R38, R45, R50, R56, R61, R65, R73, R74, and R79 were assessed and replaced by Sept 5, 2017. All other residents with toilet safety frames are at risk for this deficient practice. These frames were also assessed and if found to have loose armrests were replaced. After root cause analysis by the Safety Committee, all of the loose equipment was found to be one brand. This brand will no longer be purchased or used by this center. All of the toilet safety frames found to be safe were of a different brand. All toilet safety frames have been and will continue to be inspected during our quarterly room inspections and with room turnover. The Housekeeping and Laundry Supervisor who completes these inspections will be trained on what to look for during these inspections by Sept. 5, 2017. The facility has a system for reporting of maintenance requests. All staff will be re-educated by Sept. 5, 2017, on using this system to report these types of issues, as well as what makes equipment unsafe and the need to report those items to the maintenance hotline. A random audit of 10 toilet safety frames will occur 1x weekly for 4 weeks, 2x per month for 2 months, and then 1x per month for 3 months. Audit reports will be	

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F 323	Continued From page 23 by the bed, he got up and walked over by the dresser and was heading to the bathroom when he fell. Under other info staff indicated resident was ambulating without shoes, glasses or his front wheel walker that all of these three things contributed to the fall. The Fall Scene Huddle Worksheet at correlated that R69 was not wearing his glasses, only had socks on and was not using his walker. Written on worksheet without staff name, date or time "sign on walker/gripper socks." -5/27/17, at 10:35 a.m., Incident Report indicated staff found R69 on the floor next to the nurse's station recliner laying on his left side. Resident did not remember going down and stated he didn't hit his head. Under other info it indicated that resident was sitting in the recliner next to the nurses' station and staff had just walked past him and was sitting there content. The Fall Scene Huddle Worksheet correlated that staff had just walked by him about one minute between last staff member contact and fall. Under comments Alzheimer's was written and that resident's mindset was to get up, resident was moved to a different location and asked if he needed to go to the bathroom which resident indicated no. - 6/8/17, at 9.:48 a.m., Incident Report indicated that R69 slipped off his be onto the floor which was witnessed by a staff member walking by his room. R69 indicated that he did not know what happened. Under other info staff indicated he had removed his shoes. The Fall Scene Huddle Worksheet indicated R69 removed his shoes and tried to self-transfer to the wheelchair and was slipping off the bed. It also indicated that the resident removed his shoes, worksheet did not indicate if he was bare feet or if he only had	F 323	reviewed by the QAPI committee with appropriate follow-up initiated.	

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socks on and gripper socks were applied.

- 6/30/17, at 4:15 p.m., Incident Report indicated that R69 was found on a wet floor where he was self-transferring, he was incontinent of urine and was not wearing shoes. It further indicated that resident was toileted and gripper socks were put on. The corresponding Fall Scene Huddle Worksheet indicated that resident was found on the floor in his room, R69 was incontinent of urine and did not have shoes on. Interventions were given Tylenol (a mild analgesic) and scheduled hypertensive medication.

- 7/11/17, at 3:35 a.m., Incident Report indicated that R69 was found on the floor laying on his left side with gripper socks on, the back of his t-shirt was wet and that there was some urine on the floor. The Fall Scene Huddle Worksheet indicated the resident was attempting to self-transfer and at that time of the fall R69 was not using assistive device.

- 7/26/17, at 1:32 p.m., Incident Report indicated that R69 was found lying on his left side on the floor by the blue chair by desk and stated he did not know where he was going. Under other info it indicated that resident did have gripper socks on. The Fall Scene Huddle Worksheet indicated that R69 had just taken a medication and used the toilet before sitting in the blue chair which staff assisted him in, got him comfortable and put his feet up. Staff noted that the root cause was that he did not know where he was going.

Review of facility Safety Committee Minutes dated 6/7/17, identified R69 as one of five residents that had multiple falls. Per incident report reviewed prior to 6/7/17, R69 fell on

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5/12/17, at 1:40 p.m. and 5/27/17, at 10:35 a.m. The Safety Committee Minutes dated 7/5/17, indicated that many of the residents listed on the fall list resided in the secured unit of the facility.

During an interview on 7/26/17, at 1:01 p.m., NA-C stated R69 needed assistance in daily grooming and was a stand by assist for transfers. When asked about his bed alarm she stated that staff would run to him when the bed alarm sounded, she further indicated the alarm sounded if R69 rolled over or if he lifted his leg in bed. NA-C stated the alarm was initiated because R69 had been crawling in and out of bed unsafely and had some falls.

During an interview on 7/27/17, at 12:40 p.m., the director of nursing (DON) stated the facility looked at the number of falls and trending of falls during their safety meetings. She stated they looked at the overall fall picture including the time of day or anything that stuck out and the location of falls. The DON further stated they identified there had been more falls in the special care unit and most occurred on the evening shift.

During an interview on 7/27/17, at 1:14 p.m. RN-C stated R69 had diagnoses of Parkinson's and dementia that he did not track on time. She stated R69 believed he was stronger than he was and his impulsivity was a factor in his falls. RN-C further stated R69's physical weakness and cognitive impairment with his dementia also factored into when he was falling and stated the key would be better supervision when he was at the desk and keeping him busy.
R93's annual Minimum Data Set (MDS) dated 4/5/17, indicated she was severely cognitively impaired, required extensive assistance from two

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staff for toileting and transfers, and was frequently incontinent of bowel and bladder. A Care Area Assessment (CAA) dated 4/10/17, identified a fall since admission and indicated the use of an alarm. The CAA indicated R93 would pick the alarm up with her when making unsafe transfers. The CAA further indicated R93 was at risk for further falls due to her dementia.

R93's care plan dated 3/30/17, indicated a self-care deficit related to dementia and an inability to perform activities of daily living independently. The care plan directed staff to assist with ambulation, toilet use and transfers. The care plan further identified a risk for falls exhibited by a history of falls. Care planned interventions included: ensure proper foot wear was worn, bed alarm, check every 15 minutes while in bed, do not leave her alone and a rocker chair and mechanical cat on her lap.

During an observation on 7/25/17, at 2:04 p.m. R93 was lying in bed. Her eyes were open and she was moving around in the bed. At 2:35 p.m. R93 continued to lay in bed wide awake. At 2:51 p.m. she remained in bed awake.

During an observation on 7/26/17, at 7:13 a.m. R93 was in bed. R93 remained in her room in bed until 8:21 a.m. with no staff observed to check in on her.

A review of facility untitled incident reports identified the following:

- 3/30/17, R93 was found lying on the floor on her back with a trash bag on her foot. No injuries were observed. A Falls Tool identified R93 had one or more falls in the past three months,

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restlessness, confusion and difficulty following instructions. A Correlating Good Samaritan Society - Windom Progress Note dated 4/1/17, indicated a personal alarm was implemented due to unsteadiness and lack of call light use. There was no evidence a root cause analysis was performed to identify causal factors of fall.

- 4/23/17, staff responded to alarm sounding and found R93 lying in the supine position on the floor beside her bed. R93 sustained a 1 centimeter laceration to the right side of her head and a right elbow abrasion. A correlating Good Samaritan Society - Windom Progress Note dated 4/23/17, indicated R93 had a headache from the laceration on the right side of her skull. There was no evidence a root cause analysis was performed to identify causal factors of fall.

- 5/12/17, R93 was found lying on the floor on her right side in the doorway of room 512. She was unable to state what happened. There was no evidence a root cause analysis was performed to identify causal factors of fall.

A Falls Tool dated 5/24/17, indicated R93 had sustained a fall or found on floor. There was no evidence of a facility incident report. A correlating Good Samaritan Society - Windom Progress Noted dated 5/26/17, indicated implementation of the use of an alarming wheel chair cushion. There was no evidence a root cause analysis was performed to identify causal factors of fall.

- 6/8/17, R93 was found on the floor. She was sitting in her wheel chair in the hallway prior to fall. Wheel chair alarm was in place and working. There was no evidence a root cause analysis was performed to identify causal factors of fall.

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- 6/21/17, R93 was lowered to the floor by staff following an attempt to self-transfer from a stationary chair to her wheel chair. There was no evidence a root cause analysis was performed to identify causal factors of fall.

- 7/1/17, R93 res found semi-sitting on the floor. She appeared to have been attempting to pull herself up into a standing position using the desk and her hands slipped. A correlating Good Samaritan Society - Windom Progress Note dated 7/2/17, indicated dementia is the root problem of standing up and self-transferring.

- 7/4/17, R93 found on the floor by kitchen staff who came to clear tables. She was lying on her left side in front of the nurses' desk rubbing the right side of her head. Nothing noted on head. There was no evidence a root cause analysis was performed to identify causal factors of fall.

During an interview on 7/26/17, at 1:42 p.m. nursing assistant (NA)-C stated R93 had not had too many falls that she could think of. She stated R93 used to try to crawl out of bed or stand out of her chair, NA-C stated She had a new wheel chair because it reclined and she could sleep in it. She stated R93 no longer attempted to transfer independently.

During an interview on 7/27/17, at 9:22 a.m. registered nurse (RN)-C stated R93 had a history of falls from the previous facility. RN-C stated she had a personal alarm and stated the nurses should be documenting when it went off to attempt to determine a pattern but was not sure if anything had been documented. She stated R93 had been removing the alarm from her chair so a

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different type of alarm was initiated. RN-C stated the facility was currently working on teaching the nurses how to look at the root cause of falls. She stated the facility's interdisciplinary team had discussed R93's falls but was not sure what had been identified as the cause of her falls.

During an interview on 7/27/17, at 9:55 a.m., the director of nursing (DON) stated the facility had a fall worksheet used to direct the staff to think about how each fall occurred. She stated the nurse on the floor at the time of the fall should implement an initial intervention until the case manager can look at the bigger picture and the care plan. She stated the interdisciplinary team discussed the falls at a morning meeting and if there is a need for discussion, that happens. The DON stated the case manager was responsible for evaluation of the care plan. She stated the facility had a falls committee but stated she did not always attend the meetings. She stated she did a trending of falls in the facility and looked at who had had multiple falls and looked for patterns. The DON further stated she did not know how much was documented. She stated the case manager should be documenting a narrative of what's happening in the Progress Notes each quarter.

A facility policy titled Good Samaritan Society Fall Prevention and Management dated July 2015 was reviewed. The policy indicated the risk of falling in long term care facilities substantially increases due to decreased mobility, frailty, muscle weakness, gait disturbance and disease process. Every Good Samaritan Society skilled care location will have a fall prevention and management program.

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A facility policy titled Fall Committee Guidelines dated September 2013 indicated the interdisciplinary team should meet regularly to formalize a fall prevention and management program. The policy further directed staff to use root cause analysis to assist in determining the true causes of falls and attempts to keep the falls from recurring.
During an environmental tour on 7/26/17, at 10:30 a.m. with the director of maintenance (DM), the following residents were observed to have toilet safety frames with loose arm rests. The loose arm rests were verified with the DM. All of the arm rests were observed to move approximately one to three inches back and forth.

R6's annual Minimum Data Set (MDS) dated 4/21/17, indicated R6 was unsteady during transfers and had a functional limitation of an upper extremity. The care plan dated 4/22/17, indicated R6 was at risk for falls related to weakness. The Falls Tool dated 5/12/17, indicated risk factors including a recent fall.

R13's annual MDS dated 4/7/17, indicated R13 was not steady during transfers. The care area assessment (CAA) worksheet dated 4/18/17, indicated R13 had impaired balance and muscle weakness during transfers. R13's care plan dated 7/3/17, identified falls on 11/13/16 and 6/7/17.

R14's CAA worksheet dated 9/9/16, indicated impaired mobility related to muscle weakness and identified five falls in the past two months. A Falls Tool dated 2/4/17, indicated R14 had one or more falls in three to twelve months and was at risk due to impaired cognition. The care plan revised on 5/16/17, indicated R14 was unable to stand and transfer safely due physical weakness, had been

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found by facility staff on the floor and had a history of a fall with a serious injury prior to admission. R14's quarterly MDS dated 5/19/17, indicated unsteadiness during transfers.

R16's CAA worksheet dated 11/15/16, identified an increased risk for falls related to weakness and hemiparesis. The care plan revised on 1/16/17, indicated R16 was at risk for falls related to weakness and had a fall with minor injuries. A quarterly MDS dated 4/21/17, indicated R16 was unsteady during transfer related to functional impairments involving one side of R16's body.

R24's care plan dated 11/23/16, indicated R24 was at risk for falls related to weakness and identified a fall had occurred in the facility. R24's annual MDS dated 6/16/17, indicated R24 was not steady during transfers. A CAA worksheet dated 6/16/17, indicated a potential for falls related to weakness and decreased mobility. .

R25's CAA worksheet dated 1/3/17, identified a risk for falls related to generalized muscle weakness. The care plan revised on 3/20/17, indicated R25 was at risk for falls related to generalized weakness and gait/balance difficulty. The care plan further denitrified falls on 11/10/16, 12/27/16, 2/5/17, and 6/30/17. R25's quarterly MDS dated 6/9/17, indicated R25 was not stable during transfers.

R26's CAA worksheet dated 3/24/17, indicated impaired balance during transitions. The care plan revised on 3/30/17 indicated R26 had impaired vision, muscle weakness and impaired cognition. The quarterly MDS dated 6/2/17, indicated R26 was not stable during transfers.

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R27's care plan dated 4/15/16, identified limited physical mobility related to a compression fracture in the lower spine and a fall on 6/26/16, had occurred when R27 was with family. The Falls Tool dated 6/28/16, indicated mobility risk factors including impulsivity, reduced insight and confusion. .The CAA worksheet dated 3/27/17, indicated R27 had impaired balance during transitions and impaired cognition. The quarterly MDS dated 6/9/17, indicated R27 was not steady during transitions .

R29's care plan revised on 1/19/17, indicated R29 was at risk for falls related to decreased mobility and vision and had a fall in the facility. A CAA worksheet dated 1/27/17, indicated R29 had the potential for falls related to decreased mobility and had fallen in the past two to six months. R29's quarterly MDS dated 6/23/17, indicated R29 was not stable during transitions.

R32's care plan dated 1/16/17, indicated a risk for falls related to weakness, forgetfulness and terminal prognosis and identified falls in the facility on 2/27/17, 3/13/17, 5/01/17, and 6/21/17. R32's significant change MDS dated 2/20/17, indicated R32 was not steady during transfer.

R38's care plan dated 6/9/16, indicated a risk for falls related to weakness and identified a fall in the facility. R38's annual MDS dated 4/14/17, indicated unsteadiness during transfers. A CAA worksheet dated 4/26/17, indicated R38 was at risk for falls due to weakness.

R45's CAA worksheet dated 11/25/16, indicated R45 had impaired balance during transition and difficulty maintaining sitting balance. The care

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plan revised on 12/1/16, indicated R45 was at risk for falls related to cognitive impairment and decreased safety awareness. The care plan further indicated R45 fell on 2/3/17. The quarterly MDS dated 4/28/17, indicated R45 was not steady during transfers related to functional impairments on both sides of the body.

R50's quarterly MDS dated 5/26/17, indicated R50 was not steady during transfers. The CAA worksheet dated 7/27/17, identified limited physical mobility and weakness. The care plan revised on 12/5/17, indicated R50 had limited physical mobility related to arthritis and weakness.

R56's quarterly MDS dated 4/14/17, documented a need for extensive assistance during transfer. The CAA worksheet dated 7/7/17, indicated a fall history related to self-transfer and impaired balance. The care plan revised on 7/18/17, indicated R56 had falls related to hemiparesis and refusal of staff assistance.

R61's care plan revised on 5/12/16, indicated R61 was at risk for falls related to poor vision in right eye. The care plan further identified three falls had occurred in the facility.

R65's admission MDS dated 6/8/17, indicated R65 was unsteady during transfers due to impairment on one side of the body. The care plan dated 7/13/17, indicated R65 was at risk for falls due to weakness secondary to a left hip fracture and had fallen prior to admission.

R73's annual MDS dated 6/9/17, indicated R73 was unstable during transitions. A CAA worksheet dated 6/20/17, indicated R73 was at risk for falls

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related to weakness and had impaired balance during transitions. The care plan revised on 6/26/17, identified a risk for falls related to weakness and previous falls in the facility including one in the bathroom.

R74's care plan dated 12/12/16, indicated R74 was at risk for falls related to falls prior to admission. The care plan further identified multiple falls in the facility, including one in the bathroom. A CAA worksheet dated 2/23/17, indicated R74 had impaired balance during transitions.

R79's CAA worksheet dated 4/10/17, identified a high risk for falls due to dementia. R79's care plan dated 6/15/17, indicated a potential for falls related to physical weakness and cognitive impairment. A quarterly MDS dated 6/16/17, indicate R79 was unsteady during transitions due to functional limitations of all extremities.

During an interview on 7/26/17, at 11:45 a.m. the DM stated the equipment maintenance request process instructed all facility staff to call the maintenance hot line to communicate needed repairs. He stated the line was checked multiple times per day by a member of the maintenance staff and the requests were documented in an on-line data base. The DM was unable to provide documentation of requests involving toilet safety frames.

During an interview on 7/26/17, at 12:30 p.m. the director of housekeeping (DH) stated that she completed resident room inspections every three months following a Resident Room Inspection Report. The DH stated that she "grabs those bars" as part of the inspection. The DH was

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F 323	Continued From page 35 unable to provide a report noting any concerns with commodes or fixtures. The DH stated that housekeeping staff clean the toilet and attached equipment daily and could have noticed and reported loose equipment to the nursing or maintenance staff. During an interview on 7/27/17 at 10:53 a.m., the director of nursing (DON) stated housekeeping staff should have told nursing staff if the toilet safety frames were loose or housekeeping staff should have called the maintenance's hotline. The DON stated the responsibility for resident safety "rests on the nursing staff." Policies and procedures for resident room inspections and equipment maintenance's were requested and received.	F 323		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Windom was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2017

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Windom is a one-story building with partial basement, and was constructed at five different times. The original building was constructed in 1959, with building additions in 1962, 1972, 1994 and 2000. All buildings were determined to be of Type II(111) construction. The facility is fully sprinklered. The building has a fire alarm system with smoke detection in the corridors, including all spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a capacity of 78 beds and had a census of 67 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 926	NFPA 101 Gas Equipment - Qualifications and	K 926		8/29/17

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 926 SS=D	Continued From page 2 Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is not met as evidenced by: Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This deficient practive could effect 67 of 67 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 07/26/2017, documentation could not be located to show that staff that handle medical gas have been properly trained per NFPA 99. This deficient practice was verified by the Facility Maintenance Director.	K 926	K-926 Corrected Date: Aug. 29, 2017 It is the current policy and procedure of GSS-Windom to provide oxygen education to all licensed nurses and trained medication aides upon hire. Current licensed nurses and trained medication aides will be educated on the application, maintenance, handling, and risks of oxygen on August 29, 2017. Similar training has been added to our annual training program. The Safety Coordinator and Maintenance Director will monitor the facility for future training issues through the QAPI committee.	