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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TLTU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00082

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245595**
2.STATE VENDOR OR MEDICAID NO.
(L2) **017840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WESTBROOK**
(L4) **149 FIRST STREET, BOX 218**
(L5) **WESTBROOK, MN** (L6) **56183**

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 **02/24/2015** (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 **40** (L18)

13.Total Certified Beds **40** (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
	40			
(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 :
Kathryn Serie, Unit Supervisor 02/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/16/2015 (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
01/01/1992
(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
02/26/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245595

March 16, 2015

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, Minnesota 56183

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 February 7, 2015 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 25, 2015

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, Minnesota 56183

RE: Project Number S5595025

Dear Ms. Wepplo:

On January 28, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 15, 2015. 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 February 24, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 11, 2015 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 January 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 7, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 15, 2015, effective February 7, 2015 and therefore remedies outlined in our letter to you dated January 28, 2015, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245595	A. Building B. Wing	2/24/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WESTBROOK	149 FIRST STREET, BOX 218 WESTBROOK, MN 56183

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **02/07/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **02/07/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/07/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/07/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	02/25/2015	03048	02/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/15/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245595	A. Building B. Wing 01 - MAIN BUILDING 01	2/11/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WESTBROOK	149 FIRST STREET, BOX 218 WESTBROOK, MN 56183

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	01/15/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	02/25/2015	19251	02/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/15/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TLTU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00082

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245595**
2.STATE VENDOR OR MEDICAID NO.
(L2) **017840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WESTBROOK**
(L4) **149 FIRST STREET, BOX 218**
(L5) **WESTBROOK, MN** (L6) **56183**

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 **01/15/2015** (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 **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(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 :
Wendy Buckholz, HFE NE II 02/06/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/23/2015 (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
01/01/1992
(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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 28, 2015

Ms. Nancy Wepplo, Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, Minnesota 56183

RE: Project Number S5595025

Dear Ms. Wepplo:

On January 15, 2015, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 February 24, 2015, 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 April 15, 2015 (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 July 15, 2015 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112

Enclosure

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
	245595	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WESTBROOK	149 FIRST STREET, BOX 218 WESTBROOK, MN 56183

(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 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct a comprehensive assessment after a significant change for 1 of 1	F 274	F-274 Corrected Date: Feb. 7, 2015	2/7/15

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

Electronically Signed | 02/06/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING _____ B. WING _____	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WESTBROOK	149 FIRST STREET, BOX 218 WESTBROOK, MN 56183

(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 274	Continued From page 1 resident (R25) reviewed who experienced a significant decline in activities of daily living (ADL) and toileting abilities. Findings include: During review of R25's quarterly minimum data set (MDS) assessment, dated 12/18/14, it was noted R25 had a decline in activity of daily living (ADL) abilities in the following areas: bed mobility, transferring, walking in corridor, locomotion off unit, dressing, toileting, and level of incontinence. On the previous quarterly MDS assessment, dated 10/2/14, R25 was identified as requiring supervision of one staff with bed mobility, dressing, toileting and transferring and was identified to require limited assistance with walking in corridor and locomotion off unit. Further, the MDS identified R25 had occasional incontinence. The most recent quarterly MDS, dated 12/18/14, identified R25 required extensive assistance of staff with bed mobility, walking in corridor, locomotion off unit, dressing, and toileting. R25 was also identified to be frequently incontinent of bladder. R25 had experienced a decline in abilities in all of the identified areas. During interview on 01/14/2015, at 9:15 a.m. registered nurse (RN)-A stated R25 had been requesting additional assistance with toileting on the night shift and was more dependent on staff per R25's choice. RN-A stated R25's condition had not declined but R25 had requested more assistance with cares. RN-A stated she did not feel this was a temporary condition change but a	F 274	It is the current policy and procedure of GSS-Westbrook to conduct comprehensive assessments, including significant changes, as identified, for every resident. The significant change assessment process started on Jan 22, 2015 for R25, to accurately assess and reflect R25□s current needs, as well as appropriate interventions. All residents are at risk and will have their MDS□s audited for significant changes to assure the plan of care and CAA□s are written to reflect any significant changes by Feb. 7, 2015. The case manager was re-educated on Feb. 5, 2015, by the Evangelical Lutheran Good Samaritan Society Skilled Nursing Consultant, regarding significant changes, including how to identify and write a CAA when there are changes in condition, as well as possible interventions. An audit of significant condition changes will be conducted 1x per week x3 months or until all residents have been through one care planning cycle by the QAPI Coordinator or designee. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated. _____	

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F 274	Continued From page 2 more permanent change. RN-A stated there had been no significant change in R25's health status but R25 requested additional staff assistance. During interview with certified nursing assistant (NA)-A on 01/15/2015, at 7:51 a.m. NA-A stated R25 required more assistance for the past couple months. NA-A stated R25 was assisted to wash up at night with incontinence and needed staff assistance with dressing and toileting in the morning. During interview with R25 on 01/15/2015, at 10:43 a.m. R25 stated she needed staff to physically assist her with dressing especially putting her stockings on. R25 stated staff assisted her with transfers when they were in the room. R25 stated she had difficulty with incontinence during the night and required staff assistance to help her toilet and wash. The facility failed to conduct a significant change assessment and corresponding Care Area Assessments (CAA) when it was noted R25 demonstrated a significant change (decline) in her activities of daily living and toileting needs.	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		2/7/15

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F 279	Continued From page 3 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a care plan for 1 of 1 resident (R20) who had been assessed at risk for falls and had sustained a fall and struck her head. Findings include: R20 was admitted on 3/16/10 and had diagnoses that included: irritable bowel syndrome, anxiety, pelvic and thigh pain, arthropathy and history of a right hip pathological fracture. R20 was receiving medications which included: Ativan (anti-anxiety medication) 0.25 milligrams (mg) every day (qd); Lexapro (anti-depressant) 20 mg qd; Fentanyl 12 micrograms (mcg)/hr patch; Neurontin 300 mg twice daily and hydrocodone 5-325 mg twice daily. During interview with registered nurse (RN)-A on 01/12/15, at 4:50 p.m. RN-A stated R20 had experienced a fall in her room on 1/1/15 and struck her head. RN-A stated staff conducted neurological checks and monitored R20 after the fall.	F 279	F-279 Corrected Date: Feb. 7, 2015 It is the current policy and procedure of GSS-Westbrook to assess and develop appropriate care plans, regarding falls, for every resident. The care plan for R20 was updated on Jan. 15, 2015 to reflect fall potential and appropriate interventions. An audit will occur of all residents Fall Risk UDA□s to determine potential fall risk and will have their care plans reviewed and updated as necessary by Feb. 7, 2015. The case manager was re-educated on Feb. 5, 2015, by the Evangelical Lutheran Good Samaritan Society Skilled Nursing Consultant, regarding fall assessments, corresponding care planning, and appropriate interventions.	

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F 279	Continued From page 4 During review of R20's progress notes, dated 1/1/15 a note at 1:50 p.m. indicated the RN was called to R20's room by a nursing assistant (NA), not identified in note, and R20 was found on the floor lying on her right side by the television tray and dresser. R20 told the RN she had struck her forehead during the fall and informed staff she was walking over to close the door and fell. This note identified that an assessment was conducted to evaluate for injuries and neurological checks were initiated post fall. R20 was subsequently assisted with the use of a mechanical lift to return to the chair in her room. During review of R20's care plan, dated 11/19/14, R20 was identified with limited physical mobility related to generalized weakness, osteoporosis and arthritis. R20 was also identified with the ability to ambulate only very short distances. The care plan identified R20 as being independent with wheelchair mobility but the care plan lacked any problems, goals and/or interventions related to falls. A Fall Evaluation dated 1/1/15, was conducted which identified that R20 did not have a history of falls and only ambulated short distances in her room. The evaluation identified R20's wheelchair as the primary mode of mobility. The evaluation further identified that R20 utilized the psychoactive medications Ativan (anti-anxiety) and Lexapro (anti-depressant) daily. Risk factors included on the evaluation were age, cardiovascular conditions, psychiatric conditions, use of analgesics, use of psychoactive medications and gait/balance disturbance. The planned intervention related to the fall was to educate R20 to call for staff assistance when in	F 279	An audit of fall UDA□s for all residents will be conducted 1x per week x3 months by the QAPI Coordinator or designee. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated. _____	

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F 279	Continued From page 5 her room and when needing help to close her door. The facility conducted a Fall Risk assessment, dated 5/19/14, prior to fall on 1/1/15 which identified R20 at high risk for falling related to age, health conditions, medications, gait, balance and mobility. During interview with R20 on 1/14/15, at 12:50 p.m. R20 stated she fell on 1/1/15 because she was standing from her wheelchair and trying to kick her room door shut. R20 stated she lost her balance and went straight down onto the floor. R20 stated she was instructed by staff to ask for help, which she will in the future, because she has had a pathological fracture in her right hip and does not want to fracture it again. During interview with RN-A on 1/15/14, at 9:30 a.m. it was verified the current/active care plan lacked any identification of fall risks, goals and/or planned interventions.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 follow the plan of care related to the identification and protection of skin related issues for 1 of 4 residents (R18) reviewed	F 282	F-282 Corrected Date: Feb. 7, 2015 It is the current policy and procedure of	2/7/15

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F 282	Continued From page 6 for non-pressure related skin conditions. Findings include: During review of R18's care plan, dated 12/24/14, R18 was identified with a self care deficit with all cares. The care plan identified that R18 required 1 to 2 staff assist with activities of daily living (ADL) due to aggressive behavior and dementia. Interventions included on R18's care plan were: wear left and right arm protectors due to skin tears and history of hitting out during cares. The facility policy titled Routine Daily Practice, revised 10/2013 identified that Routine daily practices were services that were expected to be provided for all residents and not captured on the care plan or specifically documented in the medical record. The routine daily guidelines for nursing included the following: Check skin weekly and report to the licensed nurse. During observation and interview on 1/13/15, at 2:00 p.m. R18 was observed seated in her wheelchair in her room with a large bruise located on the right forearm. R18 stated, "No" when asked if anyone had harmed her, but was unable to state how the bruise had occurred. No arm protectors were evident. On 1/14/15, at 8:30 a.m. R18 was observed located in her room and independently eating her breakfast meal. It was observed that R18 was not wearing protective sleeves as directed by the care plan. On 1/14/2015, at 8:35 a.m. during an interview with LPN-A she stated she was unaware of any bruising on R18's right forearm and that nursing assistants were instructed to report bruising and/or any injury that was noted during cares.	F 282	GSS-Westbrook to follow the care plan for every resident and to follow the Routine Daily Practice Policy. R18□s care plan was reviewed and found to be appropriate in regard to wearing arm sleeves. A skin assessment was initiated on Jan. 14, 2015, for R18 with appropriate follow up conducted and documented. All residents are at risk for this deficient practice. All nursing staff will be re-educated regarding following care plans and the daily practice routines and their responsibilities based on their position in these processes by Feb. 7, 2015. Licensed nurses will also be re-educated on skin assessment documentation and appropriate follow up and monitoring of skin conditions. An audit for following care plan interventions and daily practice routines, of various staff on various shifts, will be conducted 3x□s per week x1 month, then 1x per week x2 months, by the QAPI Coordinator or designee. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated. _____	

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F 282	Continued From page 7 During an interview with the interim director of nursing services (DNS) on 1/14/15, at 1:10 p.m. it was verified the bruising on R18's right forearm was not observed until the morning of 1/14/15. The DNS further stated a skin assessment should have been completed on 1/13/14 during R18's weekly bath (prior day). The DNS also verified staff had not identified the bruising but should have at the time of the skin assessment. The DNS verified staff had not followed the policy related to weekly skin monitoring for bruising and/or injury during bathing for R18 and that weekly skin assessments were expected as part of the Routine Daily Practice Policy which was part of the care plan. The facility failed to follow R18's care plan that identified R18 was to have left and right arm protectors on when up to reduce the risk of skin injury.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify and monitor bruising for 1 of 4 residents (R18) reviewed for non-pressure related skin issues.	F 309	F-309 Corrected Date: Feb. 7, 2015 It is the current policy and procedure of	2/7/15

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F 309	Continued From page 8 Findings include: It was observed on 1/12/14, at 7:31 p.m. that R18 had an area of purple discoloration (bruising), which measured approximately 9 centimeters (cm) x 7 cm, located on her right forearm. R18 did not offer a response when asked whether she knew the reason for the bruising. During observation and interview on 1/13/15, at 2:00 p.m. R18 was observed seated in her wheelchair in her room with a large bruise located on the right forearm. R18 stated, "No" when asked if anyone had harmed her, but was unable to state how the bruise had occurred. When R18's electronic medical record (EMR) was reviewed, documentation and monitoring related to the noted bruise was lacking. Review of the nursing progress note dated 1/13/15, at 13:54 identified R18's skin as warm, dry and intact. The note further identified R18's skin was free of redness and pressure areas. During review of R18's treatment record sheets from December 2014 to January 2015 it was revealed there were no skin concerns documented related to bruising. R18's care plan dated 10/16/14 identified a potential for alteration in skin related to fragile skin. Interventions for maintenance of skin integrity were to use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surfaces. The care plan identified R18 as being resistive to care related to a diagnosis of dementia evidenced by hitting and kicking staff at times during routine cares. R18's quarterly Minimum Data Set (MDS)	F 309	GSS-Westbrook to follow the care plan for every resident and to follow the Routine Daily Practice Policy. R18□s care plan was reviewed and found to be appropriate in regard to wearing arm sleeves. A skin assessment was initiated on Jan. 14, 2015, for R18 with appropriate follow up conducted and documented. All residents are at risk for this deficient practice. All nursing staff will be re-educated regarding following care plans and the daily practice routines and their responsibilities based on their position in these processes by Feb. 7, 2015. Licensed nurses will also be re-educated on skin assessment documentation and appropriate follow up and monitoring of skin conditions. An audit for following care plan interventions and daily practice routines, of various staff on various shifts, will be conducted 3x□s per week x1 month, then 1x per week x2 months, by the QAPI Coordinator or designee. Audit reports will be reviewed by the QAPI committee with appropriate follow-up initiated.	

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F 309	Continued From page 9	F 309		

assessment dated 11/6/14, identified R18 with a Brief Interview for Mental Status (BIMS) score of 13 which indicated mild cognition impairment. The quarterly MDS further indicated R18 had mild depression. R18 was also identified on the MDS to require extensive assistance with bed mobility, dressing, and personal hygiene. R18 was identified to be totally dependent on staff for transfers, locomotion and toileting.

On 01/14/2015, at 8:35 a.m. during an interview with LPN-A she stated she was not aware of any bruising on R18's right forearm and that nursing assistants would report bruising or injury if it was observed during cares.

During an interview with the interim director of nursing services (DNS) on 1/14/15, at 1:10 p.m. it was verified the bruising on R18's right forearm was not observed until the morning of 1/14/15. The DNS further stated a skin assessment should have been completed on 1/13/14 during R18's weekly bath (prior day). The DNS also stated staff had not identified the bruising but should have at the time of the skin assessment. The DNS verified the facility did not have a specific policy related to weekly skin assessments but they were included as part of the Routine Daily Practice Policy.

The facility policy titled Routine Daily Practice, Issued September 2012 and Revised 10/2013 identified Routine daily practices were services that were expected to be provided to all residents and not captured on the care plan or specifically documented in the medical record. Guidelines for nursing included: Check skin weekly and report to the licensed nurse.

During interview with the DNS on 1/14/15, at 1:10

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F 309	Continued From page 10 p.m. she verified staff had not followed the policy related to weekly skin monitoring for bruising and/or injury during bathing for R18.	F 309		

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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, on January 15, 2015. At the time of this survey, Building 01 of Good Samaritan Society Westbrook was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 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	

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Electronically Signed		02/06/2015

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us and, 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. Building 01 of Good Samaritan Society Westbrook was constructed as follows: The original building was built in 1961, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction; The first addition was built in 1969, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction; The second addition was built in 2001, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction The facility has a complete automatic fire alarm system, with smoke detection in the corridors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 29 at time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/15/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WESTBROOK	**149 FIRST STREET, BOX 218** **WESTBROOK, MN 56183**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide smoke barrier walls construction that meets the requirements of NFPA 101 - 2000 edition, Sections 19.3.7.3 and 8.3. This deficient practice could affect 15 residents including, staff and visitors. Findings include: On facility tour between 8:30 AM and 11:30 AM on 1/15/2015, it was observed that the south smoke barrier wall had penentrations around wires that were not properly sealed with fire rated material not in accordance with 19.3.7.3. This deficient practice was confirmed by the	K 025	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	1/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/15/2015**

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GOOD SAMARITAN SOCIETY - WESTBROOK	**149 FIRST STREET, BOX 218** **WESTBROOK, MN 56183**

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K 025	Continued From page 3 Maintenance Supervisor.	K 025	K-25 Corrected Date: Jan. 15, 2015 The compromised smoke barrier in question was filled on Jan. 15, 2015. All other smoke compartments were checked on Jan. 15, 2015 and found to be in compliance, by the maintenance director. The Safety Coordinator and Maintenance Director will monitor the facility for future issues through the Safety Meeting audits and the QAPI committee, particularly if an outside contractor has been in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **03 - 2007 ADDITION** B. WING _____	**01/15/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WESTBROOK	**149 FIRST STREET, BOX 218 WESTBROOK, MN 56183**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 15, 2015. At the time of this survey, Building 03 of Good Samaritan Society Westbrook was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 03 of Good Samaritan Society Westbrook includes a 2007 building addition, consisting of a new main entrance, lobby and offices. In 2011, the dietary department was fully remodeled. These additions are one-story, have no basement, are fully sprinklered and were determined to be of Type V(111) construction. The facility has a complete automatic fire alarm system, with smoke detection in the corridors and in spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 29 at time of the survey.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/06/2015

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.