*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
December 27, 2023

Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, MN  56183

RE: CCN: 245595
Cycle Start Date: December 6, 2023

Dear Administrator:

On December 6, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 6, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 6, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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December 27, 2023

Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
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Re: State Nursing Home Licensing Orders
Event ID: V1IR11

Dear Administrator:

The above facility was surveyed on December 4, 2023 through December 6, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| 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 _____ | C 12/06/2023 |

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

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| E 000 | Initial Comments<br><br>On 12/4/23 through 12/6/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance.<br><br>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.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained. | E 000 | | |
| E 039 | EP Testing Requirements<br>CFR(s): 483.73(d)(2)<br><br>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).<br><br>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:<br><br>(i) Participate in a full-scale exercise that is | E 039 | | 1/4/24 |

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

Electronically Signed | 01/03/2024

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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| E 039 | Continued From page 1<br>community-based every 2 years; or<br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.<br>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For Hospices at 418.113(d):]<br>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:<br>(i) Participate in a full-scale exercise that is community based every 2 years; or | E 039 | | |

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| E 039 | Continued From page 2<br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from | E 039 | | |

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| E 039 | Continued From page 3<br>engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the | E 039 | | |

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| E 039 | Continued From page 4<br>onset of the emergency event.<br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.<br><br>*[For PACE at §460.84(d):]<br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 | E 039 | | |

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| E 039 | Continued From page 5<br>years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.<br><br>*[For LTC Facilities at §483.73(d):]<br>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that | E 039 | | |

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| E 039 | Continued From page 6<br>may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.<br><br>*[For ICF/IIDs at §483.475(d)]:<br>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:<br>(i) Participate in an annual full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or | E 039 | | |

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| E 039 | Continued From page 7<br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.<br><br>*[For HHAs at §484.102]<br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:<br>(i) Participate in a full-scale exercise that is community-based; or<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.<br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br>(B) A mock disaster drill; or<br>(C) A tabletop exercise or workshop that is | E 039 | | |

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| E 039 | Continued From page 8<br>led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.<br><br>*[For OPOs at §486.360]<br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.<br>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br><br>*[ RNCHIs at §403.748]:<br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group | E 039 | | |

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| E 039 | Continued From page 9<br>discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure exercises had been conducted to test their Emergency Preparedness (EP) plan at least annually, including unannounced staff drills. This deficient practice had the potential to affect all 31 residents residing at the facility.<br><br>Findings include:<br><br>Interview and review of the EP plan and policy on 12/6/23 at 9:22 a.m., with the administrator identified they had not completed or planned a full-scale exercise or table top exercise to test their emergency plan. The administrator agreed the facility had not followed the EP plan or policy. | E 039 | 1. A table top drill with analysis thereof, was completed for the year of 2023 on 1-4-2024<br>2. All residents residing in the facility have the potential to be affected by this deficient practice<br>3. The QAPI committee will review and schedule emergency drills and review emergency operations monthly at the facility's QAPI committee meetings to ensure completion and compliance. The committee has put together a schedule for emergency drills for 2024.<br>4. The Emergency Preparedness plan will be discussed at QAPI meetings for further compliance tracking and further recommendations. This will be completed by the administrator or designee | |
| F 000 | INITIAL COMMENTS<br><br>On 12/4/23 through 12/6/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. | F 000 | | |

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| F 000 | Continued From page 10<br>The following complaints were reviewed with NO deficiencies cited: H55959942C (MN92262), H55957491C (MN93282), H55957490C (MN92625), H55957489C (MN91432), and H55957477C (MN93022).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a | F 758 | | 1/17/24 |

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| F 758 | Continued From page 11<br>specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and record review the facility failed to have an appropriate diagnosis and target behavior for the use of an antipsychotic medication for 1 of 5 residents reviewed (R21).<br><br>Findings include:<br><br>R21's 10/11/23, annual Minimum Data Set (MDS) | F 758 | 1. Resident 21's diagnosis list was updated to the ICD-F22, Delusional disorder. This diagnosis was linked to the quetiapine fumarate. R21's personal care physician will be asked to review the medication and diagnosis, and to trial a gradual dose reduction on Doctor rounds week of 1-9-2024. | |

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| F 758 | Continued From page 12<br>assessment identified R21's cognition was severely impaired, he felt down, depressed, or hopeless 2 of 6 days per week, and had diagnoses of anxiety disorder and depression. R21 was taking a anti-psychotic on a routine basis and also took an anti-depressant. The assessment lacked identification of any target behaviors in order to determine efficacy of medication therapy.<br><br>R21's December 2023, Medication Administration Record (MAR) printed 12/5/23, identified R21 was administered quetiapine fumarate (anti-psychotic) 25 mg tablet two times a day for mood related to anxiety.<br><br>R21's undated care plan printed on 12/5/23, identified R21 was taking antipsychotic medication for anxiety with behaviors with interventions to consult with pharmacy and health care provider to consider a dosage reduction when appropriate and to monitor for possible side effects. There was no mention what behavior specifics R21 exhibited to indicate if staff would be aware to identify medication efficacy or the need to alter treatment.<br><br>Review of R21's nurse practitioner (NP) progress note on 8/11/22, identified a plan of care to continue with quetiapine two times a day and Ativan as needed because the improvement in his anxiety outweighs the risk of memory loss and falls. On 3/30/23, the NP identified a diagnosis of anxiety and paranoia. At the time of survey the facility had not yet updated R21's medical record to include the added diagnosis of paranoia.<br><br>Interview on 12/05/23 at 10:48 a.m., with director of nursing (DON) identified R21 was placed on | F 758 | 2. All residents receiving anti- psychotic medication were reviewed for appropriate diagnosis and dose reduction. R-21's targeted behaviors include stating people coming into his room and calling him profane names. Increased anger with labile mood or agitation, feels threatened by others and resident to resident altercation.<br>3. Educate all charge nurses and admit personnel, social worker, HIM, MDS nurse to make sure that any admitted person with an antipsychotic medication has an appropriate diagnosis. As well as orders to monitor for behaviors. Education includes the policy: Psychotropic Medication: Rehab/Skilled. Nursing education will be on 1-11-2024 and all staff education will be on 1-17-2024.<br>4. Audits will be conducted on R21 and 3 other random residents plus any new admits or current residents on any antipsychotic medications. Weekly x4 then Monthly x2. All results will be taken monthly to the QAPI committee for further recommendations. This will be completed by the DNS or designee. | |

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| F 758 | Continued From page 13<br>quetiapine while in the hospital for aggressive and violent behavior. She agreed the diagnosis was incorrect and nursing should have clarified the reason for the medication with the physician in order to establish a baseline.<br><br>Review of the facility provided Psychotropic Medication Policy identified residents would not be given psychotropic medication unless they were necessary to treat a specific condition as diagnosed and documented in the clinical record. | F 758 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can | F 761 | | 1/11/24 |

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| F 761 | Continued From page 14<br>be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure 1 of 2 E-kits (emergency kit) did not have expired medication and also ensure staff removed expired medications from the medication carts.<br><br>E-Kit<br>Observation, interview, and document review on 12/4/23 at 7:16 p.m. with registered nurse (RN)-A in the medication room identified a locked emergency medication container. The E-kit medication list on back of the E-kit listed four packages, one tablet of tramadol 50 milligram pills, that had expired on 10/18/23. Review of E-kit log sheet indicated the local pharmacy last checked the E-kit on 10/20/23. RN-A stated E-kit medications were checked and replaced by the pharmacy for expired medication during their monthly visits.<br><br>Interview on 12/05/23 at 1:11 p.m., with local licensed pharmacist (RPh)-A identified they agreed the E-kit had expired medication. It was last checked in October of 2023. Her expectation was the E-Kit would be checked monthly for expired medication, however, the facility should be ensuring the security tab was in fact intact to identify potential diversion as soon as possible.<br><br>Review of March 2023, Medication: Acquisition Receiving, Dispensing and Storage policy indicated all medications would be packaged and labeled in accordance with state pharmacy regulations and controlled medications would be reconciled through receipt and disposition by the licensed pharmacist. | F 761 | 1. Both of the facility's emergency kits and facility medication care were reviewed and updated as needed to ensure no expired medications are in the E-kits and cart on 12/30/2024.<br>2. All residents in the facility have the potential to be affected by this practice. E-kit and Medication cart were checked for expired medications on 12-30-24.<br>3. Education will be given to nursing staff at the nursing meeting on 1-11-2024, on the policy: Emergency Drug Boxes-R/s, LTC. A new procedure is that the night shift nurse will check the E-kit and the Medication/Treatment cart for expired medication weekly on Wednesdays. This new process started on 1/3/2024.<br>4. Audits for expired medications in E-kits and Medication/Treatment carts will be conducted weekly x4 then monthly x2. Results will be taken to monthly QAPI committee meetings for further recommendations. This will be completed by the DNS or designee. | |

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| F 761 | Continued From page 15<br><br>Medication Cart<br>Observation on 12/06/23 at 7:36 a.m., of the facility medication cart identified 1 OTC (over the counter) bottle of Tylenol tablets that expired on February 2023. In addition, R3 had a bottle of omeprazole 40 mg (milligram) capsules had expired on 1/18/23. R3 also had OTC calcitriol which expired on 2/25/23, 37 remaining Folic acid tablets which expired on 4/05/23, 57 furosemide tablets that had expired on 7/19/23, and 100 tablets of vitamin B 12, which expired from the manufacturer on 10/17/23.<br><br>Interview on 12/06/23 at 8:40 a.m., with LPN-A identified OTC medications that were expired should not be kept with medications that were in use. The facility's common practice was for those medications to be removed from the cart and replaced when reported off to another staff. LPN-A agreed medications that had expired should be removed from the cart as to not inadvertently administer those medications to a resident.<br><br>Interview on 12/06/23 at 11:22 a.m., with the interim DON identified she would expect the medication cart to be check routinely for outdated medications and remove those medications when discovered as part of the medication administration process for administration.<br><br>Review of the March 2023, Medications: Acquisitions Receiving Dispensing and Storage policy identified the facility staff will check and dispose expired medications in accordance with state pharmacy regulations. | F 761 | | |
| F 851 SS=F | Payroll Based Journal | F 851 | | 12/29/23 |

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| F 851 | Continued From page 16<br>CFR(s): 483.70(q)(1)-(5)<br><br>§483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format.<br>Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS.<br><br>§483.70(q)(1) Direct Care Staff.<br>Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).<br><br>§483.70(q)(2) Submission requirements.<br>The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:<br>(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);<br>(ii) Resident census data; and<br>(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, | F 851 | | |

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| F 851 | Continued From page 17<br>but not limited to, start date, end date (as applicable), and hours worked for each individual).<br><br>§483.70(q)(3) Distinguishing employee from agency and contract staff.<br>When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.<br><br>§483.70(q)(4) Data format.<br>The facility must submit direct care staffing information in the uniform format specified by CMS.<br><br>§483.70(q)(5) Submission schedule.<br>The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information at least quarterly or more often, including information for agency and contract staff, based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 3) in Federal Fiscal Year 2023, to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. The facility also failed to have a policy for PBJ that instructed how and when staff were to submit data and run verification reports to ensure data submitted was complete and accurate. This has the potential to affect all 34 residents residing in the facility. | F 851 | 1. All residents could be affected without proper staffing including the 8hr RN oversight and supervision.<br>2. Education was completed with the office manager on 12/29/2023, the office manager is responsible for reporting PBJ data. The PBJ needs to include anytime an office RN, the DNS or any contracted Nurse is covering nursing hours on the floor.<br>3. Education was given to the office manager on PBJ reporting. The administrator reviewed the location procedure for PBJ reporting with the office manager. Education was given to the DNS and the MDS nurse to give the office | |

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| F 851 | Continued From page 18<br>Findings include:<br><br>Review of the Payroll Based Journal Report (PBJ) Casper Report 1705D for Quarter 3, 2023 (April 1 through June 30), identified the facility triggered for failing to have licensed nursing coverage 24 hours per day. The following dates were triggered for review: 4/2/23, 4/16/23, 5/7/23, 6/10/23, 6/18/23, 6/20/23, 6/25/23, 6/26/23, and 6/28/23.<br><br>Review of the nursing timecard punches for the infraction dates identified above on the 1705D identified the facility did have licensed staff who worked, therefore the data submitted was inaccurate and nor not complete.<br><br>Interview on 12/06/23 at 10:18 a.m., with the adminsitrator identified that they in fact had licensed staff on for the dates indicated but the previous administrator did not enter the PBJ information correctly.<br><br>There was no policy related to PBJ entries provided by the end of the survey. | F 851 | manager any hours worked on the floor.<br>5. We will submit the facility report monthly and also run a validation report to confirm we have proper staffing levels.<br>4.Audits will be conducted for all nursing on the PBJ report. Weekly x4 and then Monthly x 2. The administrator will audit the PBJ quarterly statement prior to submission. This will start when the January submission for the 4th quarter of 2023 is due. Results will be taken to monthly QAPI committee meetings for further recommendations. This will be completed by the Administrator or designee. | |
| F 883 SS=E | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically | F 883 | | 1/2/24 |

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| F 883 | Continued From page 19<br>contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the | F 883 | | |

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| F 883 | Continued From page 20<br>pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 4 of 5 (R3, R4, R12 and R24) residents were appropriately vaccinated against pneumococcal disease upon admission and/or offered updated vaccination per Centers for Disease Control (CDC) vaccination recommendations.<br><br>Findings include:<br><br>Review of the current CDC pneumococcal guidelines located at https://www.cdc .gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below:<br>a) If NO history of vaccination, offer and/or provide:<br>aa) the PCV-20 OR<br>bb) PCV-15 followed by PPSV-23 at least 1 year later.<br>b) For PPSV-23 vaccine ONLY (at any age):<br>aa) PCV-20 at least 1 year after prior PPSV-23 OR<br>bb) PCV-15 at least 1 year after prior PPSV-23<br>c) For PCV-13 vaccine ONLY (at any age):<br>aa) PCV-20 at least 1 year after prior PCV13 OR<br>bb) PPSV-23 at least 1 year after prior PCV13<br>d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years:<br>aa) PCV-20 at least 5 years after last | F 883 | 1. Resident R12 and R24 were consented and administered PCV-20 on 12/18/2023. R3 and R4 were given PCV-20 on 1-2-24, after consent was obtained.<br>2. All residents were reviewed and consents sent out to families of those who are unable to give consent on 12/22/2023.<br>3. All new admits and any current residents who become eligible for vaccine updates will be reviewed on admission, at care plan review and will be updated immunization for the pneumococcal vaccination status for all residents, new admits or current residents who become eligible a vaccine update will be conducted weekly x 4 and then Monthly x 2. All results will be taken to QAPI for further recommendations. This will be completed by the DNS or designee. | |

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| F 883 | Continued From page 21<br>pneumococcal vaccine dose OR<br>bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose<br>e) Received PCV-13 at Any Age AND PPSV-23 AFTER Age 65 Years:<br>aa) Use shared clinical decision-making to decide whether to administer PCV-20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine.<br><br>Review of 4 sampled residents for vaccinations identified:<br><br>1) R3 was 90 years old and was admitted on May of 2023. R3 received PPSV-23 on 10/13/04 and PCV-13 on 8/12/16. There was no documentation to support R3 had been offered the PCV-20 to ensure she was updated with current CDC guidance for vaccines.<br><br>2) R4 was 85 years old and was admitted on October of 2015. R4 received PPSV-23 on 12/11/04 and 9/20/11 and PCV-13 on 6/03/17. There was no documentation to support R4 had been offered the PCV-20 to ensure she was updated with current CDC guidance for vaccines.<br><br>3) R12 was 77 years old and was admitted on January of 2023. R12 received PPSV-23 on 11/21/06, 3/3/11 and 8/18/14. R12 received PCV-13 on 10/08/15. There was no documentation to support R12 had been offered the PCV-20 to ensure she was updated with the current CDC guidance for vaccines.<br><br>4) R24 was 81 years old and was admitted on January of 2023. R24 received PCV-13 on 12/03/15 and 5/22/17. There was no documentation to support R24 had been offered | F 883 | | |

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| F 883 | Continued From page 22<br>the PCV-20 to ensure she was updated with the current CDC guidance for vaccines.<br><br>Interview on 12/06/23 at 10:21 a.m., with licensed practical nurse (LPN-B) who is the facility Infection Preventionist (IP) confirmed residents was not offered and/or administered PCV-20 and lacked a declination of refusal for vaccine upon admission to the facility.<br><br>Review of September 2023, Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other, AL, R/S, LTC, HBS policy identified pneumococcal immunizations would be offered according to CDC recommendations upon admission and per CDC guidelines for eligibility.<br><br>Review of October 2023, Infection Prevention and Control Program, All Service Lines policy identified facility would promote the facility immunization program ensuring residents were provided education including the risk and benefits, administration, and declination of immunizations in accordance with current standards of practice. | F 883 | | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On 12/4/23 through 12/6/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and | 2 000 | | |



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

Electronically Signed | 01/03/24

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| 2 000 | Continued From page 1<br>identify the date when they will be completed.<br><br>The following complaints were reviewed during the survey: H 55959942C MN92262, H 55957491C MN93282, H55957490C MN92625, H55957489C MN91432, MN93022 H55957477C and NO licensing orders were issued.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is | 2 000 | | |

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| 2 000 | Continued From page 2<br>enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 302 | MN State Statute 144.6503 Alzheimer's disease or related disorder train<br><br>ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING:<br>MN St. Statute 144.6503<br><br>(a) If a nursing facility serves persons with Alzheimer's<br>disease or related disorders, whether in a segregated or general unit, the facility's direct care staff<br>and their supervisors must be trained in dementia care.<br><br>(b) Areas of required training include:<br>(1) an explanation of Alzheimer's disease and related disorders;<br>(2) assistance with activities of daily living;<br>(3) problem solving with challenging behaviors; and<br>(4) communication skills.<br>(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic | 2 302 | | 12/29/23 |

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| 2 302 | Continued From page 3<br>topics covered.<br>(d) The facility shall document compliance with this section.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review the facility failed to ensure that 2 out of 8 staff (trained medication aide (TMA)-A and the director of nursing (DON)) received Alzheimer's training upon hire or annually per facility policy.<br><br>Findings include:<br><br>Review of TMA-A's employee file identified a hire date of 11/16/22. TMA-A's training record lacked evidence of annual Alzheimer's training having occurred from Nov 2023 thru the date of the survey.<br><br>Review of the DON's employee file identified the DON was recently hired on 8/2/23. The DON's training record lacked evidence of Alzheimer's training upon hire.<br><br>During an interview with human resources (HR) on 12/5/23 at 2:56 p.m., HR reported Alzheimer's training is required for new hires and then annually. HR was unable to verify the DON had received Alzheimers dementia training upon hire. Hr agreed TMA-A had no annual training performed in November 2023 through the survey date.<br><br>During an interview with DON on 12/5/23 at 3:30 p.m., she confirmed she had not had Alzheimer's training upon hire. | 2 302 | 1. The IDNS completed training on 12/29/2023. The TMA-A completed training on 12/19/2023.<br>2. All new hires will complete Alzheimer's Dementia training prior to working on the floor.<br>3. The Administrator or Education trainer will ensure all staff is enrolled in appropriate Alzheimer's Dementia training with completion time frame given to the employee.<br>4. Audits will be Monthly x6 for new hire compliance. Results will be reported to the QAPI committee for further recommendation. | |

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| 2 302 | Continued From page 4<br><br>During an interview with the administrator on 12/6/23 at 4:15 p.m., the administrator confirmed Alzheimer's training was part of orientation and was to be completed yearly.<br><br>The policy titled Orientation-Employee Enterprise dated 7/21/23, stated orientation must be completed within 30 days of the employee's start date. Progress is monitored by human resources.<br><br>The policy titled Competency and Mandatory Education Requirements dated 5/22/23, identified the facility was responsible to provide processes for ongoing education and competency achievement that would include annual or initial training.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure all staff should be enrolled in the appropriate Alzheimer's training courses and notify them of a timeline for completion. The facility should ensure a system to audit facility education to be done following new staff orientation and throughout the year as appropriate. The results of those audits should go to the QAPI committee ongoing to ensure continued compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 302 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease | 21426 | | 1/17/24 |

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| 21426 | Continued From page 5<br><br>Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 2 of 2 staff (interim director of nursing (DON) and the administrator) received the required two-step tuberculin skin test (TST) testing and symptom screening.<br><br>Findings include:<br><br>Review of the employee health file for the interim DON identified they were hired on 8/2/23. The first step for TST (tuberculin skin test) was not administered prior to employment on 8/2/23. The Interim DON-C received the first step TST on 12/04/23, which was 125 days beyond thier hire date.<br><br>Review of the employee health file for the administrator identified they were hired on 11/27/23. The first step TST was not administered prior to employment on 11/27/23. The | 21426 | 1. The IDNS and Administrator completed the 2 step TB skin tests on 12/22/23.<br>2. New hires will complete a 2 step TB test upon hire.<br>3. The IP will review the policy and procedure related to screening and testing. Education will be given to staff at the all staff meeting on 1/17/2024. Any staff who miss the meeting will be educated prior to the first day returning to work.<br>4. Audits for TB testing will be done Monthly x 6. Results will be reported to the QAPI committee for further recommendations by the IP nurse or designee. | |

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| 21426 | Continued From page 6<br><br>administrator received their first step TST on 12/4/23, which was 7 days beyond thier hire date.<br><br>Interview on 12/05/23 at 11:14 a.m., with licensed practical nurse (LPN)-B who is the facility IP (Infection Prevetionist) when asked for TST screenings for interim DON and administrator, IP lacked the documentation of administration of TST.<br><br>Interview on 12/04/23 at 5:20 p.m. with IP confirmed she did not complete a TST on these employees upon hire and would start the first TST today nor had they had a symptom screening performed upon hire.<br><br>Interview on 12/06/23 at 11:22 a.m. with interim DON-C indicated she received first step on 12/04/23 and would be read on 12/06/23.<br><br>10/21/22's Tuberculosis Control Plan and Screening for employees, Senior Living, Rehab/Skilled, Home Health, Child Day-Enterprise policy indicated baseline TB screening was to be provided for new employees and would follow CDC (Center for Disease Control) guidelines.<br><br>SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents and/or staff records to ensure compliance. The | 21426 | | |

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| 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) COMPLETE DATE |
|---|---|---|---|---|
| 21426 | Continued From page 7<br><br>ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty one-(21) days. | 21426 | | |

| 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**<br>B. WING _____ | **12/06/2023** |

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

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/6/2023. At the time of this survey, Good Samaritan Society-Westbrook was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>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.<br><br>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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION | K 000 | | |

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

Electronically Signed | 01/03/2024

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<br>IS NOT REQUIRED.<br><br>Healthcare Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St. Paul, MN 55101-5145, OR<br><br>By email to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>Building 01 of Good Samaritan Society Westbrook was constructed as follows:<br>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;<br>The first addition was built in 1969, is one-story, has no basement, is fully fire sprinkler protected | K 000 | | |

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| K 000 | Continued From page 2<br>and was determined to be of Type II(222) construction;<br>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<br>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.<br><br>These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.<br><br>The facility has a capacity of 32 beds and had a census of 30 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 355 SS=D | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation staff interview, the facility failed to install a portabble fire extinguisher per NFPA 101 (2012 edition), Life Safety Code, section | K 355 | 1. The fire extinguisher in the kitchen was repaired and hung back on the wall on 12/7/23. | 12/8/23 |

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| K 355 | Continued From page 3<br>19.3.5.12 and NFPA 10 (2009 edition) section 6.1.3.4. This deficient finding could have a isolated impact on the residents within the facility.<br><br>Findings include:<br>On 12/6/2023 at 11:00AM, it was revealed by observation that the K Class Fire Extinguisher was not mounted on the wall in the kitchen.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 355 | 2. The dietary staff were educated about the requirement to have all fire extinguishers mounted and secured in the department and off the floor on 12/8/2023.<br>3. All staff will be educated on this life safety code requirement at the staff meeting on 1/17/2024.<br>4. Audits will be conducted on the facility fire extinguishers Weekly x4 then Monthly x 2. This will be completed by the Maintenance Director or designee. | |
| K 923 SS=D | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on | K 923 | | 1/11/24 |

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| K 923 | Continued From page 4<br>each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier.<br>Empty cylinders are segregated from full cylinders.<br>When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain correct oxygen cylinder storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. This deficient finding could have a isolated impact on the residents within the facility.<br><br>Findings include:<br>On 12/06//2023, at 10:30 AM, it was revealed by observation that in the O2 Storage Room, there was mixed storage of empty/full cylinders. There was no identified storage areas for full and/or empty cylinders.<br><br>An interview with the Maintenance Director verified this deficient finding at the time of discovery. | K 923 | 1. The O2 storage rooms has clear signage of the empty and full O2 cylinders and where their storage is as of 12/7/2023.<br>2. The Nursing staff have been educated on the proper location for the oxygen storage cylinders on 1/11/2024.<br>3. Audits will be conducted of the storage room for proper storage Weekly x4 and then monthly x2 and results will be reviewed at the monthly QAPI committee meetings for further recommendations.<br>This will be completed but the maintenance Director or designee. | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
January 23, 2024

Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, MN  56183

RE: CCN: 245595
Cycle Start Date:

Dear Administrator:

On January 19, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance.  Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered

January 23, 2024

Administrator
Good Samaritan Society - Westbrook
149 First Street, Box 218
Westbrook, MN  56183

Re: Reinspection Results
Event ID:  V1IR12

Dear Administrator:

On January 19, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 6, 2023.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us