DEPARTMENT (OF I	HEALTH A	ND HI	UMAN	SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
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ID. YIFW

	PART I	- TO BE COMP			TE SURVEY AGENCY	Facility ID: 00085		
I. MEDICARE/MEDICAID PRO (L1) 245558 2.STATE VENDOR OR MEDICAI (L2) 677840200		 NAME AND AI (L3) GOOD SAM (L4) 705 SIXTH 5 (L5) WINDOM, 1 	IARITAN SOCI STREET		NDOM (L6) 56101	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
 5. EFFECTIVE DATE CHANGE (L9) 6. DATE OF SURVEY 	OF OWNERSHIP 10/03/2018 (L34)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	IPPLIER CATEGO 05 HHA 06 PRTF	RY 09 ESRD 10 NF	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
 ACCREDITATION STATUS: 0 Unaccredited 1 T 	(L10)	02 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31		
11LTC PERIOD OF CERTIFICA From (a): To (b):	TION	Complian	nnce With Requirements ice Based On:	3:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit7. Medical Director		
12.Total Facility Beds13.Total Certified Beds	78 (L18)78 (L17)	B. Not in Co	Acceptable POC mpliance with Prog and/or Applied Wa		4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: A *	 Beds/Room (L12) Patient Room Size 		
14. LTC CERTIFIED BED BREA	KDOWN	1			15. FACILITY MEETS			
18 SNF 18/19 7	SNF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L33	8) (L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY F	REMARKS (IF APPLICABI	E SHOW LTC CANC	ELLATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:		
Holly Kranz, Unit S	upervisor	10/08	8/2018	(L19)	Alison Helm, Enforcement Specialist 10/08/2018 (L20)			
	PART II - TO BI	E COMPLETED	BY HCFA RI	EGIONAI	OFFICE OR SINGLE ST.	ATE AGENCY		
 DETERMINATION OF ELIG 1. Facility is Eligib 2. Facility is not E 	le to Participate		MPLIANCE WITH GHTS ACT:	CIVIL	 Statement of Finan Ownership/Contro Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)		
22. ORIGINAL DATE	23. LTC AGREEN	1ENT 2	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 05/01/1991	BEGINNING	DATE	ENDING DAT	Е	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	5		
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspensio	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change		
(L27	7) B. Rescind Su	spension Date:	(L44) (L45)			00-Active		
28. TERMINATION DATE:	29). INTERMEDIARY/			30. REMARKS			
- · · · ·	_	00140						
	(L28)	00140		(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	ATE				
	(L32)			(L33)	DETERMINATION APPR	OVAL		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 5, 2018

CMS Certification Number (CCN): 245558

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 19, 2018 the above facility is recommended for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 5, 2018

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

RE: Project Number S5558026

Dear Administrator:

On August 29, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 3, 2018. (42 CFR 488.422)
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 28, 2018.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on August 10, 2018 that included an investigation of complaint number H5516035. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 3, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 11, 2018 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 an abbreviated standard survey, completed on August 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 19, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on August 10, 2018, as of September 19, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 19, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of August 29, 2018:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 28, 2018.

In our letter of August 29, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from

Good Samaritan Society - Windom October 5, 2018 Page 2

conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 28, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 19, 2018 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

DEPARTMENT O	F HEALTH A	ND HUMAN	SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
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ID: YJFW

	PART I	- TO BE COMP	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00085	
1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY (L1) 245558 (L3) GOOD SAMARITAN SOCIETY - 2.STATE VENDOR OR MEDICAID NO. (L4) 705 SIXTH STREET (L2) 677840200 (L5) WINDOM, MN					NDOM (L6) 56101	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSH (L9)	IIP	7. PROVIDER/SU	PPLIER CATEGOF 05 HHA	XY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 08/10/2018 8. ACCREDITATION STATUS:	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds	; (L18)	Compliant		:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code	6. Scope of Services Limit7. Medical Director	
13.Total Certified Beds 78	(L17)	X B. Not in Cor			-		
14. LTC CERTIFIED BED BREAKDOWN		Requirements	and/or Applied Wai	vC15.	* Code: B * 15. FACILITY MEETS	(L12)	
18 SNF 18/19 SNF 78	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARKS (IF a	APPLICABL	E SHOW LTC CANCE	ELLATION DATE)	:			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:	
Susan Kalis, HFE NE II		(09/24/2018	(L19)	Alison Helm, Enforcement Specialist 10/05/2018		
PART I	I - TO BE	E COMPLETED	BY HCFA RE	GIONAI	OFFICE OR SINGLE ST	ATE AGENCY	
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible 	(L21)		IPLIANCE WITH G GHTS ACT:	CIVIL		acial Solvency (HCFA-2572) l Interest Disclosure Stmt (HCFA-1513) :	
22. ORIGINAL DATE 23. LT	IC AGREEM	IENT 24	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION E 05/01/1991	BEGINNING	DATE	ENDING DATI	E	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety	
(L24) (l	L41)		(L25)		02-Dissatisfaction W/ Reimburseme	5	
		VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	
(1.27)		n of Admissions:	(L44) (L45)			07-Provider Status Change 00-Active	
28. TERMINATION DATE:	29	. INTERMEDIARY/O			30. REMARKS		
(L2		00140		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	ATE			
(L3:				(L33)	DETERMINATION APPR	OVAL	



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

August 29, 2018

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

RE: Project Numbers S5558026, H5338024

Dear Administrator:

On August 10, 2018, an abbreviated 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required. At the time of the August 10, 2018 abbreviated standard survey this department completed an investigation of complaint number H5516035 that was found to be substantiated.

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

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

Appeal Rights - the facility rights to appeal imposed remedies;

<u>Informal Dispute Resolution</u> - 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

Good Samaritan Society - Windom August 29, 2018 Page 2 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), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, MN 56001 Email: holly.kranz@state.mn.us Phone: (507) 344-2742 Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; <u>OR</u>
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) <u>AND</u> has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

Good Samaritan Society - Windom August 29, 2018 Page 3

• State Monitoring effective September 3, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 28, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 28, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 28, 2018.

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

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Windom is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 28, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

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 remedy be imposed:

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

Failure to submit an acceptable PoC 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred Good Samaritan Society - Windom August 29, 2018 Page 5

between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 9, 2019 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Good Samaritan Society - Windom August 29, 2018 Page 6

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY IPLETED
		245558	B. WING				C 10/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2010
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET /INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	00			
F 000	Emergency Prepare conducted on Augu 2018, during a rece		FC	000			
	6th, 7th, 8th, 9th, an investigation(s) wer of the standard sum an investigation of c	rvey was conducted August and 10th, 2018 and complaint re also completed at the time vey. At the time of the survey, complaint #H5558013 was found to be substantiated at					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are rour signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.					
F 580 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with Injury/Decline/Room, etc.) 14)(i)-(iv)(15)	F 5	80			9/19/18
	§483.10(g)(14) Not (i) A facility must im consult with the res consistent with his representative(s) w	ification of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is-					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						09/07/2018

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.

		AND HUMAN SERVICES				FORM	10/11/2018 APPROVED 0938-0391
				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245558	B. WING _				10/2018
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		-	5 SIXTH STREET INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	 (A) An accident inv results in injury and physician interventi (B) A significant char mental, or psychos deterioration in hea status in either life- clinical complication (C) A need to alter a need to discontin treatment due to ac commence a new f (D) A decision to tra resident from the fa §483.15(c)(1)(ii). (ii) When making n (14)(i) of this section all pertinent information is available and pro- physician. (iii) The facility must resident and the rest when there is- (A) A change in root as specified in §483. (B) A change in rest State law or regulation (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a com that is a composite §483.5) must disclosuble 	olving the resident which I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lith, mental, or psychosocial threatening conditions or ns); treatment significantly (that is, ue an existing form of dverse consequences, or to orm of treatment); or ansfer or discharge the acility as specified in otification under paragraph (g) in, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the sident representative, if any, of mor roommate assignment 3.10(e)(6); or ident rights under Federal or tions as specified in paragraph on. st record and periodically a (mailing and email) and	F 5	80			

If continuation sheet Page 2 of 109

		AND HUMAN SERVICES			FC	ORM A	10/11/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION (X3	(X3) DATE SURV COMPLETED	
		245558	B. WING	à			, 0/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F 580	PROVIDER OR SUPPLIER SAMARITAN SOCIETY - WINDOM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to notify the physician of a change of condition after a fall with injury for 1 of 3 resident (R16) and bruising which increased in size with swelling for 1 of 1 resident (R24) reviewed . Findings include: R16's Admission Record face sheet identified R16 was admitted to the facility with diagnosis including unspecified convulsions, muscle weakness and a history of falling. R16's Quarterly Minimum Data Set (MDS) assessment dated 5/18/18, indicated R16 had a Brief Interview for Mental Status score (BIMS) of 15 indicating intact cognition. The MDS also identified R16 needed supervision with one person physical assistance for transfers and walking in room and limited physical assistance of one with walking in hallway and toileting. R16's R16's current care plan, last revised 6/18/18, identified R16 had an actual fall with minor injury R/T (related to) urinary tract infection (UTI) with weakness evidenced by fell times 2 on 6/16/18.		F	580	It is the current policy and procedure of GSS-Windom to notify physicians of resident change of condition. On Aug. 8, 2018, the physician for R24 was notified regarding the change in the resident's bruised arm. As of Aug. 27, 2018, the bruise was resolved. The physician for R16 was notified on June 2018 regarding the resident's change condition after the fall. R16 had a medication review by her primary care physician on Aug. 22, 2018, as well as follow-up orthopedic appointments on 2, July 11, July 26, and Aug. 23, 2018. All residents who have falls or bruising at potential risk for this deficient practic A random audit will be conducted by S 18, 2018, by the Director of Nursing or designee to determine if the physician notification and additional random sample will be audited. Any errors found will be corrected. To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursing	4 he in 3 July g are ce. Sept. r s with ges on,	
	R/T (related to) urin weakness evidence The goal was identi usual activities with Interventions includ	nary tract infection (UTI) with			corrected. To prevent further potential deficient practice, all nursing staff will be		

Facility ID: 00085

If continuation sheet Page 3 of 109

				MB NO.	0938-039
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	045550				C
	245558	B. WING		08/	10/2018
	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
provider for s/s (sig and monitor for sigr mobility, positioning palance and lower of palance and lower of ankle fracture with s Review of incident r a.m. identified staff (nocking since resisted 5:30 a.m. as per us the floor next to the Walker next to her. what happened. Lee more swollen than of pear any weight afted pruising, able to mo and down. Review of incident r a.m. identified resid pathroom as she has wheeled R16 into the grab bar to stand up put of the room so the suddenly let self slip witnessed. The rep cause of the fall material foot was hurting sin earlier. R16 was as and 2 staff onto be as 2. Review of nursing r	ns/symptoms) pain, bruises hificant changes in gait, device, standing/sitting extremity joint function. A care 6/20/18, identified the pain/discomfort R/T right surgical repair. report dated 6/16/18, at 5:40 went into R16's room after dent did not put on call light at ual. R16 was found sitting on bathroom door frame. R16 stated she didn't know eff foot tender to touch, no other ankle. R16 not able to er assessing ankle, no ove ankle back and forth, up report dated 6/16/18, at 7:25 lent was taken to the ad her call light on. Staff he bathroom. R16 used the pot talso identified the root ay have been that R16's left ce she had fallen 2 hours asisted with the mechanical lift d. Pain rating was identified hotes are as follows:	F 58	0 policy and procedure on appropria timely notification to the physician changes in condition related to bria a fall, as well as other condition cl A random audit of residents who h falls or bruising will be conducted Director of Nursing Services or de 2x weekly for 2 weeks, 1x weekly weeks, and then every other week weeks. Audit results will be review the QAPI committee with appropri	of uising or nanges. have by the signee, for 6 c for 4 wed by ate	
	ACTION SUPPLIES CORRECTION ACTION SUPPLIER MARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From par provider for s/s (sig and monitor for sign mobility, positioning palance and lower of palance a	CORRECTION IDENTIFICATION NUMBER: 245558 ROVIDER OR SUPPLIER MARITAN SOCIETY - WINDOM SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 provider for s/s (signs/symptoms) pain, bruises and monitor for significant changes in gait, mobility, positioning device, standing/sitting palance and lower extremity joint function. A care olan problem dated 6/20/18, identified the resident had acute pain/discomfort R/T right ankle fracture with surgical repair. Review of incident report dated 6/16/18, at 5:40 a.m. identified staff went into R16's room after knocking since resident did not put on call light at 5:30 a.m. as per usual. R16 was found sitting on he floor next to the bathroom door frame. Walker next to her. R16 stated she didn't know what happened. Left foot tender to touch, no nore swollen than other ankle. R16 not able to pear any weight after assessing ankle, no pruising, able to move ankle back and forth, up and down. Review of incident report dated 6/16/18, at 7:25 a.m. identified resident was taken to the pathroom as she had her call light on. Staff wheeled R16 into the bathroom. R16 used the grab bar to stand up. Staff moved the wheelchair put of the room so to help resident. Resident suddenly let self slip to the floor. The fall was witnessed. The report also identified the root cause of the fall may have been that R16's left oot was hurting since she had fallen 2 hours parlier. R16 was assisted with the mechanical lift and 2 staff onto bed. Pain rating was identified	PF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 245558 B. WING	FDEFICIENCIES CORRECTION [X1] PROVIDERSUPPLIER DENTIFICATION NUMBER: 245558 (X2) MULTIPLE CONSTRUCTION A BUILDING CVIDER OR SUPPLIER MARITAN SOCIETY - WINDOM STREET ADDRESS, CITY, STATE, ZIP CODE TOS SIXTH STREET WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SINCE PROVIDERS PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SINCE PROVIDERS OF ALL OF CORRECTIVE ACTION SINCE (EACH CORRECTIVE ACTION SINCE REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 provider for s's (signs/symptoms) pain, bruises and monitor for significant changes in gait, mobility, positioning device, standing/sitting palance and lower extremity joint function. A care palan problem dated 6/20/18, identified the scident had actue pain/idiscomfort R/T right ankle fracture with surgical repair. F 580 Review of incident report dated 6/16/18, at 5:40 a.m. as per usual. R16 was found sitting on roore swollen than other ankle. R16 not call light at 5:30 a.m. as per usual. R16 was found sitting on roore swollen than other ankle. R16 not able to pear any weight after assessing ankle, no pruising, able to move ankle back and forth, up and down. F 1600 tender to touch, no more swollen than other ankle. R16 not bable to pear any weight after assessing ankle, no pruising, able to move ankle back and forth, up and room so to help resident. Resident suddently let self slip to the flor. The fall was winessed. The report also identified the root assue of the fall may have been that R16's left oot was hurting since she had fallen 2 hours farifier. R16 was assisted with the mechanical lift and 2 staff onto bed. Pain rating was identified as 2. F	IF DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) MULTIPLE CONSTRUCTION (X4) ADDING A BUILDING (X3) MULTIPLE CONSTRUCTION (X4) ADDING (X4) MULTIPLE CONSTRUCTION (X4) ADDING (X4)

If continuation sheet Page 4 of 109

		AND HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
					(C	
		245558	B. WING				- 10/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD SAMARITAN SOCIETY - WINDOM					705 SIXTH STREET		
				V	WINDOM, MN 56101		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREF	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
			1				
F 580	Continued From pa	ae 4		580			
1 000	amber, foul smell.	ge +		000			
		Ice pack for swelling to left					
	ankle, every 4 hours for swelling. Having	s as needed apply to left ankle					
		y pair in left ankie.					
		Resident fell twice within 2					
		nfused, states "I laid there					
		hight". She was in bed at 3:30 ed by this writer (staff). There					
		oming from room as evidence					
		bvious way she sat there all					
		t affect, and skin had no pressure. Left ankle was still					
		stration of PRN Tylenol 650					
		doctor since she is confused,					
		d incontinent of urine times 2					
		Jsed mechanical lift both times or. Resident stood up in					
		to grab bars until writer could					
		hair to assist her to pivot onto					
	toilet. That sudden buttocks.	, she went down slowly on her					
	bullocks.						
		After second fall in 2 hours,					
		m she had fallen twice, hurt left					
	, o	after 2 hours of initial fall and or. New orders received					
	(orders were for UA						
		Applied ice pack to left outer ight to dining room for					
		complaints of pain while					
	addresses tablema						
		loo pools for awalling to left					
		ce pack for swelling to left as needed. Apply to left					
	ankle for swelling P						
		effective not swollen but still					

If continuation sheet Page 5 of 109

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED		
		245558	B. WING				10/2018	
NAME OF F	PROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - WINDOM					05 SIXTH STREET VINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 580	Continued From pa hurts.	ge 5	F 5	80				
	regarding UA, order given one dose it w allergy, call MD info medication. He sta shouldn't be a prob	Received phone call from Dr. red Cipro, after resident was as noted that she had an ormed him she had allergy to ted no concern and it lem, just watch her. MD then id 100 mg twice daily for 7						
	weight on left ankle stand times two ass Left ankle not swoll pack to affected are (electronic long terr	Due to not able to bear full after her fall, now using sit to sist to use bedside commode. en but is painful. Applied ice ea. Call placed to eLTC n care Dr. available via video) icate with PRN Tylenol.						
	mg give by mouth e pain. Acetaminoph per day. Contact p	Acetaminophen tablet 650 every 4 hours as needed for en not to exceed 3,000 mg rovider/practioner if fever is rt in left ankle, rates 5 out of						
	ankle, every 4 hours	Ice pack for swelling to left s as needed. Has ice pack to en but is very tender to touch.						
	pain in left ankle. C falls 6/16/18. Spok	Phoned eLTC in regards to Change of condition after her e with (eLTC staff) about no Will receive orders via fax.						
	6/17/18, 1:23 a.m. and effective. Follow	Acetaminophen was given w up pain score 5.						
	6/17/18, 2:32 a.m. I	ce pack for swelling to left						

If continuation sheet Page 6 of 109

DEPART	FORM	APPROVED					
				וחוד		MB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
						С	
		245558	B. WING			08/	10/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH STREET		
GOOD S	AMARITAN SOCIETY	- WINDOM			VINDOM, MN 56101		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
					DEFICIENCY)		
F 580	Continued From no	ao 6		-00			
F 360	Continued From pa ankle.	де б		580			
	ankie.						
		Resident was sitting up on					
		er (staff) went by. Asked pain, stated it's better now,					
		an yesterday. Able to bear full					
		eft foot. Transferred with sit					
	to stand to bathroor	n.					
	6/17/18, Acetamino	phen 650 mg given for					
	general aches.						
	6/17/18, 5:33 a.m.	Ice pack for swelling to left					
		ain in left ankle as 8 out of 10.					
	6/17/18, 6;05 a.m. it feels the same.	Ice pack for swelling. Stated					
	6/17/18, 7:00 a.m.	Acetaminophen 650 mg					
	administration was	ineffective pain scale was a 5					
	"no help at all."						
	6/17/18, 4:15 p.m.	Resident stated I don't think I					
		It leg. When transferred with					
		nost of weight on that leg with r complaints. Denied pain					
	stated it's a little so						
	G/17/10 0.57 1	Decident stated right and le					
		Resident stated right ankle e bruise on inner right ankle.					
	Will continue to mo						
	6/18/18 2:03 a m	Acetaminophen 650 mg given.					
		e to bear weight on both legs					
	6/18/18_2·12 a m	Ice pack applied to both					
	ankles.						

If continuation sheet Page 7 of 109

		AND HUMAN SERVICES				FORM	APPROVED	
				TIDI		MB NO. 0938-0391 (X3) DATE SURVEY		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
			A. DOILD			С		
		245558	B. WING				10/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - WINDOM				05 SIXTH STREET				
				V	VINDOM, MN 56101			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFI	IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI		DATE	
			1		DEFICIENCY)			
F 580	Continued From no	~~ ⁷		-00				
F 360	Continued From pa	-	Ft	580				
		Stated "I hurt my right ankle my leg". When placed in sit to						
		r placed most of weight on						
	that leg with no faci	al grimace or complaints. Has						
		inner right foot. Stated its a						
	little sore scant swe	aling bilateral leet.						
	6/18/18, 2:48 a.m.	Ice pack for swelling to left						
	ankle. Took the pat	tchiness away.						
	6/18/18 6·58 a m	Acetaminophen 650 mg						
		. Resident stated no relief to						
	right leg and ankle							
		Deside at a second to deal						
		Resident complained of n, requesting analgesics.						
	Severe right leg pair	n, requesting analyesics.						
		Pain scale 10. Resident						
	stated no relief from	n pain.						
	6/18/18 11:57 a m	Acetaminophen 650 mg						
		mplained of severe right leg						
	and ankle pain.							
	6/19/19 1:26 p.m.	Acetaminophen 650 mg PRN						
		ineffective. Pain scale 10						
	resident stated not							
	6/18/18, 8:03 p.m. /	Acetaminophen 650 mg given.						
	6/18/18, 11:06 p.m.	Acetaminophen 650 mg						
	followup. ineffective	e pain scale 5 still hurting						
	badly.							
	6/19/18 12:03 a m	Very painful when assessing						
		v is bruised entirely around the						
	ankle and top of foo	ot is swollen more than last						
		han bear weight on it will use						
	bed pan tonight. W	/ill get X-ray tomorrow.						

If continuation sheet Page 8 of 109

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
AND I LAN O	OOTHEOTION	IDENTIFICATION NOIMBEN.	A. BUILDI	NG _		C	
		245558	B. WING	B. WING			10/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH STREET		
GOOD SA	GOOD SAMARITAN SOCIETY - WINDOM				VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From pa	ge 8	F 5	80			
	to void tonight since in both feet. Now to assist to raise up of chux. Resident will much pain to move.	Has been using the bed pan e she is having so much pain otal lift of mechanical lift with 2 if the bed to change soiled not turn, insists she's in too . Medicated with PRN Tylenol 50 mg for severe discomfort.					
	resident needs to be	Pain is so extreme that the e raised in bed using ed a bruise on under side of					
	assist out of bed wit swollen +2 and brui	Has a whirlpool bath. Two th sit to stand lift. Right foot is sed Did have a lot of pain om bed to wheelchair.					
		Acetaminophen 650 mg was ale 8. Resident continues to					
		faxed MD questioning if needs ed to swelling, bruising and f 6/16/18.					
	6/19/18, 2:41 p. m. may obtain x-ray of	Fax received from MD that right foot/ankle.					
		ily member and informed of hkle scheduled at hospital for n.					
	6/19/18, 8:10 p.m. for ankle pain.	Acetaminophen 650 mg given					
	6/20/18, 12:19 a.m.	Asleep at this time.					

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		AND HUMAN SERVICES				FORM	: 10/11/2018 APPROVED . 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245558	B. WING			08/10/2018		
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 580	 6/20/19, 7:01 a.m. given. Resident copain. 6/20/19, 8:43 a.m. Administration was Resident stated have 6/20/18, 12:25 p.m. right ankle x-ray. F 6/20/18, 12:25 p.m. right ankle x-ray. F 6/20/18, 3:30 p.m. resident complained ankle. Requesting 6/20/18, 4:01 p.m. facility around 3:30 Pain was rated at 5 6/20/18, 4:30 p.m. resident complained ankle. Requesting 6/20/18, 4:30 p.m. facility around 3:30 Pain was rated at 5 6/20/18, 4:30 p.m. facility around 3:30 Pain was rated at 5 6/20/18, 4:30 p.m. facility around 3:30 Pain was rated at 5 6/20/18, 4:30 p.m. facility around 3:30 Pain scale of 4. 6/20/18, 8:18 p.m. for pain scale of 4. 6/21/18, 3:10 a.m. given. 6/21/18, 6:17 a.m. not effective. Pain 6/21/18, 8:15 a.m. fankle. 6/21/18, 7:05 p.m. fishe had right ankle 	Acetaminophen 650 mg mplained of severe right ankle Acetaminophen 650 mg. ineffective. Pain scale 8. ving no relief. Resident left at 10:45 to get Resident left in wheelchair. Acetaminophen 650 mg given. ed of moderate pain in right analgesics. Resdient arrived back at p.m. Right ankle was splinted. Discussed pain with residnet ad mostly hurts when I lie rs on it. Stated splint supports ortable. Acetaminophen 650 mg given Acetaminophen 650 mg	F 5	580				

If continuation sheet Page 10 of 109

		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES				MB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
						(C	
		245558	B. WING			08/	10/2018	
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET WINDOM, MN 56101			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE	
F 580								
F 300	Continued From pa	-	F 5	580				
	wrapped with ace. medicate when medicate	Rates pain at 8 of 10. Will ds arrive.						
	6/21/18, 8:30 p.m. (pain level of 8.	Given Ketorolac 10 mg for						
	identified nurse call for pain. Patient re	C dated 6/17/18, at 1:00 a.m. ed requesting order for Tylenol cently sprained her left ankle, but no order for pain						
	medication. At this	time Acetaminophen 325 mg hours PRN pain was ordered.						
	The fax identified R walking to the bathr ROM (range of mot putting pressure on want to stand on lef was faxed back to t p.m. with physician this, I assume all is noted as received b	the MD on 6/16/18, at 5:40 a.m. 16 was found on the floor room with 4 wheeled walker. ion) to left ankle painful when foot, no swelling. Does not it ankle. No bruising. The fax he facility on 6/18/18, at 12:20 comment, "I was called about now well. Yes? The fax was back at facility 6/18/18. No e physician regarding pain t ankle.						
		results dated 6/20/18, type B distal fibular/lateral r the right ankle.						
	identified pain asso condition, non-phar ice and rest. The a	essment dated 6/18/18, ciated with a diagnosis or macological interventions of ssessment also identified the regime of PRN Tylenol 650 as not working.						
		h the director of nursing t 10:24 a.m. she stated staff						

Facility ID: 00085

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		AND HUMAN SERVICES				FORM	: 10/11/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED
		245558	B. WING	à			C 10/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 580	should have been in timely way than faxi was done as far as effective, pain statu what was being dor with complaints of p changed since ther She stated R16 was with walking prior to needed to be transf 2 assist. She stated called back on 6/18 back and told about swelling and chang when they faxed on should have called her in for an x-ray th bruising on the 17th right which should h stated we have pain have used to make the Tylenol was obv control. During interview wit 8/14/18, at 3:22 p.m been notified of the of the ankle. He sta the morning it happ see the fax from the 18th. At that time I and asked if everyth not hear anything b asked for an x-ray of Review of the policy 11/2016, indicates t consult with the res a significant change	n touch with the Dr. in a more ing. She verified no follow up pain medication not being is, change in condition and he to treat her. She stated bain something obviously e was swelling and bruising. s independent in her room to the falls but after the falls she ferred with mechanical lift and d the MD should have been b/18, when we received the fax t the increased pain and e in condition. She stated the 19th about an x-ray they and not faxed the Dr. to get that day. She stated they saw h, first on the left then on the nave been addressed. She her more comfortable since viously not working for pain th the attending physician on h. he stated he should have increased pain and swelling ated he was notified of the fall ened. He stated he did not e 16 until Monday morning the he stated I responded back hing was ok. He stated I did ack from them until they	F	580			

Facility ID: 00085

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DEPART	FORM	APPROVED						
		& MEDICAID SERVICES	1			MB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(-)	E SURVEY PLETED	
			_	-		(C	
		245558	B. WING			08/10/2018		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - WINDOM				705 SIXTH STREET WINDOM, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Continued From pa treatment significan change an existing commence a new for R24 R24's quarterly Min 6/1/18, indicated R2 impairment and req staff for bed mobility R24's Medication Ad dated August 2018, aspirin 81 milligram R24 was interviewe explained he develow which caused him se did not know how h it was getting bigge R24's skin care plan R24 had bruising or interventions for the monitor the location report abnormalities physician. R24's incident repor R24 was recorded a R24's progress note entries: On 7/30/18, R24 wa "Large discolored a	ge 12 http:- a need to discontinue or form of treatment or to orm of treatment. imum Data Set (MDS) dated 24 had severe cognitive juired extensive assist of two y, transfers and dressing. dministration Record (MAR) identified R24 received s (mg) on a daily basis. d on 8/6/18, at 3:30 p.m. and oped a bruise on his left arm, some occasional pain. R24 e obtained the bruise, and felt r in size. n initiated 7/31/18, indicated n their left upper arm with e staff to follow including to and size of the bruise, and s and/or lack of healing to the rt dated 7/30/18, identified ruise on his left arm, which neters (cm) by 14 cm in size.	1	580	DEFICIENCY)			

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MILIT	TPLE CONSTRUCTION		E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
						С
		245558	B. WING		08	/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET		
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 580	arm. Resident says Etiology unknown." physician progress seen by the physicia ordered staff to mor On 7/31/18, "Left up appears slight swoll any pain in shoulde On 8/5/18, "Update Bruising on his [left] that it had spread d Swelling noted arou bruising towards the lightening up, startin He states he has no extends and brings moderate pain. Ice is being managed w continue to monitor On 8/6/18, "[left] arr spread down to enti- elbow. Denies any p R24 was observed	, 'My whole arm hurts' Later on 7/30/18, R24's note identified R24 had been an for the bruising who nitor the area. oper arm is discolored and len. He did not acknowledge r as he did yesterday." on impaired skin integrity. I upper extremity was noted own to just distal of the elbow. Ind the elbow as well. The e shoulder is healing and ng to get yellowish coloration. o pain in the arm unless he extremity backwards, rated was applied to elbow and pain with scheduled Tylenol. Will ." m bruising noted that it had ire arm. Swelling noted around pain."	F 5	80		
	to his room, and reg assisted him to rem yellow bruising on h extending down his inches, followed by black colored, bruis around R24's left ar the top of the left ha left arm was swoller swelling in the elbox	wheelchair. R24 was assisted gistered nurse (RN)-D love his shirt. R24 had visible is front upper shoulder arm approximately three dark purple, at times almost ing extending down and rm and wrist area, covering and. In addition, R24's entire n with noticeably localized w region when compared to 0 stated she had observed the				

Facility ID: 00085

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	0: 10/11/2018 APPROVED 0: 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	CON	E SURVEY IPLETED
		245558	B. WING			C / 10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 705 SIXTH STREET	CODE	
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	bruise when it was report, however, ex anyone had update bruising since it was On 8/08/18, at 8:11 stated she was awa arm, and he had be using his left arm to cares. On 8/8/18, at 8:25 a stated the bruising ago" and she was r gotta work its way of expressed she was had been notified of developed, howeve or that current inter On 8/8/18, at 8:44 a R24's medical doctor the facility to notify including when brui so treatment could On 8/8/18, at 9:00 a (DON) stated she e physician when the change, which was a natural gravity cha would be coming to R24's bruising. On 8/8/18, at 12:32 interview, MD-A stat left arm bruising an ice to be applied. M	first identified on the incident plained she was not aware if d R24's physician about the s first identified. a.m. nursing assistant (NA)-A are R24 had bruising on his left een complaining of pain when o push himself up in bed during a.m. registered nurse (RN)-A "appeared a couple of weeks not concerned with it as, "It's lown but its fading." RN-A unaware if R24's physician f the bruising since it r, did not feel it had worsened ventions were not working. a.m. during a phone interview, or (MD)-A stated he expected him of changes to a resident sing and/or swelling changed	F 5	580		

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		AND HUMAN SERVICES & MEDICAID SERVICES		FORM	D: 10/11/2018 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245558	B. WING _		C 3/ 10/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From pa	ge 15	F 58	80	
F 641	identified the staff s residents' physician	ange policy dated 11/2016, hould consult with the when there is any significant sical, mental or psychosocial sments	F 64	41	9/19/18
SS=D	§483.20(g) Accurac The assessment m resident's status. This REQUIREMEN by: Based on observat review the facility fa Minimum Data Set loss and dental for R51, for prognosis tube/parental/ IV (in Findings include: R41 was admitted t with a diagnosis of significant change N quarterly MDS date received hospice ca identify R41 had a of that may result in a months as certified hospice physician of identifying R16 was with a medical prog expectancy is 6 mo its normal course, w	cy of Assessments. ust accurately reflect the NT is not met as evidenced tion, interview and document tiled to accurately code the (MDS) assessment for weight R69, for pressure ulcers for for R41 and for feeding thravenous) for R62.		It is the current policy and procedure of GSS-Windom to code the MDS's accurately for all residents. R69, R51, R41 and R62 MDS's will be reviewed and revised as appropriate and resubmitted to CMS by Sept. 10, 2018. All residents are at potential risk for this deficient practice. A random audit will be conducted by Sept. 18, 2018, to determine if there are other residents with inaccurate MDS coding in the last quarter If the audit shows 30% or more with errors, an additional random sample will be audited. Any errors found will be corrected. To prevent further potential deficient practice, all MDS nurses will be re-educated by the Director of Nursing Sept. 11-12, 2018, regarding appropriate MDS coding. By Sept. 19, 2018, MDS nurses will receive additional training on MDS coding by the Good Samaritan	

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		AND HUMAN SERVICES			C		APPROVE 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	`́сом	E SURVEY PLETED	
		245558	B. WING _				C 10/2018	
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE	
F 641	prognosis on MDS. hospice checked on have a diagnosis I of that the hospice is sta- terminally ill with a fi- expectancy of 6 mo well that could be." R51 R51's Order Summ identified R51 was 12/13/17, with diag- vascular disease. Review of the nursi 12/13/17, identified R51's admission M the presence of a s quarterly dated 3/1 4/6/18 and admissi not identify a press lesions on foot. Review of a nursing sheet dated 5/8/17, culture of left heel v treatment of Medih- Review of R51's wo dated 7/24/18, iden as including a nonh follow up noted ider completed to left heel included MRSA (mo	N)-C verified she did not code She stated, "well I have n both MDS's, but if we don't don't code it." Surveyor stated ysician signs a certification arted stating the resident is medical prognosis of life onths or less. She stated, "oh hary Report dated 8/10/18, admitted to the facility gnosis including peripheral ing admission form dated healing ulcer to left heel DS dated 12/17/17, identified stage two pressure ulcer. The 6/18, significant change dated on dated 4/2/18, MDS's did ure ulcer, but other open g home medication review , identified ulcer to left heel. A was completed and a oney to heel was started. bund nurse follow up note tified history of present illness healing ulcer May 21, 2018, which	F 64		Society Clinical Compliance Const A audit of MDS coding regarding w loss, dental status, pressure ulcer, hospice prognosis, and feeding tul be conducted by the Director of Nu Services or designee, weekly for 1 weeks, so that all residents are rev Residents will be audited during th quarterly/annual RAI assessment of Any errors found will be corrected immediately. Audit results will be reviewed by the QAPI committee w appropriate follow-up initiated to en- solutions are sustained.	veight oes, will ursing 3 viewed. eir cycle. vith		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/11/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245558	B. WING				C 1 0/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - WINDOM					05 SIXTH STREET /INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 641	focal level of arteria assessment identifi ulcer with healing c artery disease). Sir wounds have been in proliferate phase care and pressure of The care plan proble left heel ulcer. During interview on stated when R51 w on his heel was a p healed up and then thought it was from we didn't agree with administration) wou as a pressure ulcer contact the VA to cl or vascular ulcer. S reduction devices for R62 R62's 14 day PPS (medicare MDS date received parental/IV feeding tube while a During interview on stated R62 did not in stated oh this must different MDS wher	A disease. The wound ed stage 3 left heel pressure omplicated by PAD (peripheral nce patients angio on 5/21/18, healing well, heel wound now of healing, continue wound relief to heel at all times. lem initiated 4/3/18, identified 8/8/18, at 2:50 p.m. RN-E as admitted to facility the area ressure ulcer. She stated it opened up again and we vascular disease. She stated in the VA (veterans and nurse so we didn't code it . She stated they did not arify if it was a pressure ulcer She stated we used pressure or him at all times. (prospective payment system) ed 7/19/18, identified R62 had / feeding as well as had a a resident. 8/8/18, at 2:50 p.m. RN-E have a feeding tube. She have pulled over from a in he was here before I guess. a feeding tube. She verified	F 6	41			

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	FORM	APPROVED					
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245558	B. WING				_ 10/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From pa	ge 18	F 6	41			
	assessment dated steeth, obvious cavit fitting dentures. R6	sessment oral dental 5/4/17, identified broken, loose ies, many missing teeth and ill 9's care plan identified the non restorable decayed and					
	weights: 6/23/18, ⁻ which was a 3.84%	eights identified the following 194 lbs, 5/25/18 and 201 lbs loss in one month and ch was a 7.18% loss in 6					
	MDS dated 6/29/18 present (broken, loc cavity or broken tee fragments). The qu	dated 4/6/18, and quarterly , identified none of the above ose fitting dentures, likely oth, edentulous or tooth uarterly MDS also identified a n the last month or 10% in the					
	verified the MDS was stated the admissio correct and the MD accordingly for dent	8/9/18, at 9:01 a.m. RN-C as not coded correctly. She n oral/dental assessment was S should have been coded tal. She also verified that R69 ficant weight loss and that					
F 676	p.m. she verified the incorrectly. She als called it a pressure wound nurse at the ulcer, that's what it coded as such on the	h the DON 8/9/18, at 12:53 e above MDS's were coded to stated that in May the VA ulcer. She stated since the VA was calling it a pressure is and should have been the MDS. to (ADLs)/Mnth Abilities	F 6	76			9/19/18

		AND HUMAN SERVICES				FORM	10/11/2018 APPROVED 0938-0391
		(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED C			
		245558	B. WING _				10/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - WINDOM					5 SIXTH STREET INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 676 SS=D	CFR(s): 483.24(a) (§483.24(a) Based of assessment of a re- resident's needs an provide the necessa- ensure that a reside daily living do not di of the individual's cl that such diminution includes the facility §483.24(a)(1) A res- treatment and servi or her ability to carr living, including thos of this section §483.24(b) Activitie The facility must pro- accordance with pa- activities of daily livit §483.24(b)(1) Hygie grooming, and oral	1)(b)(1)-(5)(i)-(iii) on the comprehensive esident and consistent with the nd choices, the facility must ary care and services to ent's abilities in activities of iminish unless circumstances linical condition demonstrate n was unavoidable. This ensuring that: sident is given the appropriate ices to maintain or improve his ry out the activities of daily se specified in paragraph (b) es of daily living. ovide care and services in aragraph (a) for the following ing: ene -bathing, dressing, care,	F 67	76	DEFICIENCY)		
	§483.24(b)(2) Mobi including walking,	lity-transfer and ambulation,					
	§483.24(b)(3) Elimi	nation-toileting,					
	§483.24(b)(4) Dinin snacks,	ng-eating, including meals and					
	(i) Speech, (ii) Language,	munication, including I communication systems.					

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		AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>			O		APPROVEI 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED	
		245558	B. WING	B. WING			C 08/10/2018	
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM			SIXTH STREET NDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 676	This REQUIREMEN by: Based on interview facility failed to prov services for 1 of 3 m activities of daily livi (R39) reviewed for p R48 was admitted to Admission Record fi including: Parkinso fibrillation, heart fail weakness. R48's quarterly Mini assessment dated of severe cognitive im dependent on staff and required extens mobility, transfer, dr personal hygiene. R48's care plan, las the resident had a r intervention due to I related to dementia freezing gait and ph plan interventions d perform active/pass walking program 2-3 Review of R48's Do dated May 2018-Au restorative nursing the following: May 3 opportunities (5/18/ of 21 opportunities (5/18/	AT is not met as evidenced and document review the vide restorative nursing esidents (R48) reviewed for ng (ADL's) and 1 of 1 resident position mobility. o the facility on 1/5/18, per the face sheet, with diagnoses n's disease, dementia, atrial ure, pain, and muscle imum Data Set (MDS) 5/29/18 indicated R48 had pairment, was totally with locomotion on/off the unit, sive assistance with bed ressing, eating, toilet use, and at revised 7/24/18, indicated heed for restorative limited physical mobility , Parkinsonism evidenced by hysical weakness. The care irected nursing rehab staff to sive range of motion and a	F 6		It is the current policy and procedu GSS-Windom to provide residents of care and services to meet their nee R48 has passed away. R39's resto care plan was reviewed and update appropriate for positioning mobility Case Manager on Aug. 24, 2018. All residents who have restorative of plans are at potential risk for this de practice. The plans for all residents reviewed and updated as appropria the Director of Nursing Services by 24, 2018. To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nurs Sept. 11-14, 2018, regarding restor nursing care planning; including documentation, evaluation, and completion of restorative plans. Or 28, 2018, the therapy company was updated by the Administrator on the processes as well. Additionally, a r functional maintenance exercise cla be started on Oct. 1, 2018 for appro- residents. A random audit of documentation, evaluation, and completion of resto- plans for residents with restorative of plans for residents with results will be reviewed by the QAPI committee w appropriate follow-up initiated to en	with eds. prative ed as by the care efficient were te by Aug. t ing ative t a Aug. e new ew ass will opriate rative care ctor of reekly ith		

Facility ID: 00085

		AND HUMAN SERVICES				FORM	10/11/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245558	B. WING) 10/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GOOD SAMARITAN SOCIETY - WINDOM					05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	Continued From pa opportunities (8/1/1	-	Fe	676	solutions are sustained.		
	confirmed being pu the floor if someone	on 8/9/18, at 1:11 p.m. NA-E Illed from restorative to work e called in. NA-E further Illed from restorative that day.					
	confirmed being pu services to the Heri calling in. When as duties he was sche	on 8/9/18, at 2:08 p.m. LPN-A illed from restorative nursing itage Court unit due to a staff sked if the restorative nursing duled to complete would be r staff in his absence LPN-A ow.					
	physical therapist (F the majority of the r therapy and NA-E a stated when a resid therapy a restorativ PT-H confirmed it w	on 8/10/18, at 03:07 p.m. the PT)-H stated LPN-A completed restorative nursing rehab also had been trained. PT-H dent was discharged from re plan was then put into place. was nursing's responsibility to ive plan was put into place and fied nursing staff.					
	director of nursing (services (HR) direct DON stated the rest scheduled with the the monthly schedut try to have a least of scheduled daily Mo confirmed sometim staff to work on the having concerns bro- restorative plans not confirmed not track	on 8/10/18, at 3:25 p.m. the (DON) stated the human stor was in charge of staffing. storative nursing staff is day sheet and included into ule. DON further stated they one restorative nursing staff anday through Friday. DON res they had to pull restorative floor. DON further stated not ought to her related to ot getting completed. DON sing if the restorative nursing ng completed. DON reviewed					

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION	OMB NC (X3) DA	TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		COMPLETED	
		045550				С	
		245558	B. WING	STREET ADDRESS, CITY, STATE, ZIP COI		/10/2018	
NAME OF I	PROVIDER OR SUPPLIER			705 SIXTH STREET	JE		
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 676	R48's restorative pl there were so many therapy. DON conf	ge 22 an and was surprised that / "holes" in the completion of irmed she had not been told taff that programming was not	F 6	76			
	R39 was admitted t including: hemipleg unspecified cerebro right dominant side	ecord dated 8/10/18, identified o the facility with diagnoses gia and hemiparesis following ovascular disease affecting , dorsalgia, muscle weakness stive pulmonary disease.					
	she stated, I'm supp week. I get arm ar step. I am suppose band hand too. She it at all in August ye R39 took me to her spread sheet she h documented on the she received restor and 31. She stated on June 30 and since really bad. She stated	spread sheet the days in July ative. The days were 2, 5, 24 d a staff member had retired ce this occurred it has been ated one of the nurses was					
	good. She stated t very good but I have stated I am suppose Wednesday and Fri a.m. R39 was obse aide performing res looked at surveyor, shoulders and smile R39 was asked if sl	ng it and the nurse is not very there is one other girl who is en't seen her in awhile. She ed to get it Monday, iday. On 8/7/18, at 11:30 rved in the therapy room with storative exercises. R39 shook her head, shrugged her ed. On 8/9/18, at 2:05 p.m. he got walked by staff. She d to a June calendar on the					

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				. 0938-039
	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
						С
		245558	B. WING			/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 705 SIXTH STREET	JE	
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 676	back of her door an will tell you. Staff ha 17 and 18th that res that's how much I g walk 1-2 time a day all. They just didn't When asked if she stated I was able to can. I haven't done R39's quarterly MD Brief Interview for M 15 indicating intact identified a function with impairment on of two persons to w room occurred only person assistance, person with transfer supervision of one p off the unit. R39's c identified R39 requi person with walking R39's care plan, las resident had a need due to limited physic weakness and old C accident) with right inability to independ Goal: resident will n mobility of transfer using handrail. Inter range of motion (RC with red T-band, 20 times per week, act left seated exercise times per week, act	d stated well look at that, that ad initialed on June 13, 14, 15, sdient was walked. She said got walked. I was supposed to . Now they don't walk me at and I don't know why. was able to walk now she before but don't know if I still	F 6	76		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/11/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY PLETED C
		245558	B. WING				
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - WINDOM					05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 676	week, active ROM I times per week, pas reps as tolerated 3 plan updated 8/2/18 unable to ambulate using a total lift for the Review of R39's nut why resident was nep per the care plan. A surveyor identified i changes in resident able to ambulate or restorative program order for skilled the be obtained to set ut restorative program about her abilities b her. Review of R39's D dated June 2018-Au restorative nursing the following: Wall 2018, 2 times (5//1 (6/4, 6/5, 6/11, 6/15 2018, 2 times (7/3) not applicable. Aug applicable rest chee exercises: July 4 da refusals. August ti When interviewed of physical therapy aid that restorative is show much is getting	Nustep at level 5 10 min 3 solve ROM to right arm 20 times per week. The care 8, also indicated R39 was or transfer independently ransfers. rsing notes does not indicate of walked or had restorative A note written 8/8/18, (after ssue) identified that due to condition she is no longer use the Nustep as part of her . Once she has stabilized an rapy to evaluate and treat will up further orders for her . Resident is not realistic ut this has been explained to pocumentation Survey Reports ugust 2018 related to rehab completion indicated king 1-2 times per day: May 0, 5/29) June 2018, 7 times, 5, 6/18, 6/19 and 6/28). July , 7/9). 20 days were marked just times 2 (8/1 and 8/2 non cked off). Restorative any (7/2, 7/5, 7/24, 7/31) 4	F	576			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/11/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DAT COM	E SURVEY IPLETED
		245558	B. WING	à			C 10/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 676	When interviewed of confirmed being put the floor if someone confirmed being put She stated R39 get the Nustep, and ind restorative from her was working it if she best to try approach because she always explained she sees and Thursdays if sh indicated a staff me June so doesn't alw When interviewed of confirmed being put services to the Heri calling in. When as duties he was sche- provided by another stated he didn't kno When interviewed of nursing assistant (N 2 assist 20-30 feet. couple weeks, and assistants do the w When interviewed of physical therapist (f the majority of the r therapy and NA-E a stated when a resid therapy a restorativ PT-H confirmed it w assure the restoratic	on 8/9/18, at 1:11 p.m. NA-E lled from restorative to work a called in. NA-E further lled from restorative that day. s upper and lower exercises, dicated R39 had never refused r, but it depended on what staff e refused. NA-E stated it is ning R39 before bible study, s goes to that. NA-E further R39 on Monday, Tuesday, ne isn't pulled to the floor, and ember had retired at the end of vays get done. on 8/9/18, at 2:08 p.m. LPN-A lled from restorative nursing tage Court unit due to a staff sked if the restorative nursing duled to complete would be r staff in his absence LPN-A	F	676			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 245558 245558 B. WING 08/10/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101 705 SIXTH STREET WINDOM, S6101 08/10/2018			AND HUMAN SERVICES			FORM	: 10/11/2018 APPROVED 0938-0391
245558 B. WING OB(10/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE. ZIP CODE TOS SURTASTREET TOS SURTAST	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		`́сом	PLETED
GOOD SAMARITAN SOCIETY - WINDOM 705 SIXTH STREET WINDOM, MIN S6101 Image: Statement of PericleNCIES (PREW) TAG SUMMARY STATEMENT OF PERICLENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Image: PROVIDER'S PLAN OF CORRECTION (EACH OFFICETIVE ACTION SHOLD BE (EACH OFFICETIVE ACTION SHOLD BE DEFICIENCY) OWNETFING (EACH OFFICETIVE ACTION SHOLD BE (EACH OFFICETIVE ACTION SHOLD BE DEFICIENCY) OWNETFING (EACH OFFICETIVE ACTION SHOLD BE (EACH OFFICETIVE ACTION SHOLD BE (EACH OFFICETIVE ACTION SHOLD BE DEFICIENCY) OWNETFING (EACH OFFICETIVE ACTION (EACH OFFICETIVE ACTION SHOLD BE (EACH OFFICETIVE ACTION (EACH OFFICETIVE ACTION SHOLD BE (EACH OFFICETIVE ACTION SHOLD BE (EACH OFFICETIVE ACTION SHOLD BE (EACH OFFICETIVE ACTION (EACH OFFICETIVE (EACH OFFICETIVE) (EACH OFFICETIVE (EACH OFFICETIVE) (EACH OFFICETIVE (EACH OFFICETIVE) (EACH OFFI			245558	B. WING	 		
GOOD SAMARITAN SOCIETY - WINDOM WINDOM, MN 56101 (M) ID PHEFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG D PREFIX TAG PROUDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (M) DATE F 676 Continued From page 26 transferred to restorative. From January to March she was on a program. When they took her off in March she met standing and walking goals and was independent in sit to stand. Did not meet independent transfers. F 676 When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staft to work on the floor. DON further stated to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON reviewed R448's restorative plan and was surprised that there were so many "holes" in the completion of therapy. DON confirmed she had not been told by the restorative staft that programming was not getting done. The DON also stated staff should not be documenting not applicable on the restorative staft hat programming was not getting done. The DON also stated staff should not be documenting not applicable on the restorative staft hat programming was not getting done. The DON also stated staff should by the restorative staft hat programming was not getting done. The DON also stated staff should with a change in condition this week. I don't know why she did	NAME OF F	PROVIDER OR SUPPLIER	·				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 676 Continued From page 26 transferred to restorative. From January to March she was on a program. When they took her off in March she met standing and walking goals and was independent in sit to stand. Did not meet independent transfers. F 676 When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled dily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON confirmed she had not been told by the restorative staff that programming was not getting done. The DON also stated staff should not be documenting not applicable on the restorative sheats. It should be refused or not available. She statel I don't know why she didn't get it in Jume. We had someone	GOOD S	AMARITAN SOCIETY	- WINDOM				
transferred to restorative. From January to March she was on a program. When they took her off in March she met standing and walking goals and was independent in sit to stand. Did not meet independent transfers. When interviewed on 8/10/18, at 3:25 p.m. the director of nursing (DON) stated the human services (HR) director was in charge of staffing. DON stated the restorative nursing staff scheduled with the day sheet and included into the monthly schedule. DON further stated they try to have a least one restorative nursing staff scheduled daily Monday through Friday. DON confirmed sometimes they had to pull restorative staff to work on the floor. DON further stated not having concerns brought to her related to restorative plans not getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON confirmed not tracking if the restorative nursing services were getting completed. DON confirmed somany holes" in the completion of therapy. DON confirmed she had not been told by the restorative staff that programming was not getting done. The DON also stated staff should not be documenting not applicable on the restorative sheets. It should be refused or not available. She stated I don't know why she wasn't walked in July. She stated she just started with a change in condition this week. I don't know why she didn't get it in June. We had someone	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF) BE	COMPLETION
get done July and August. F 677 ADL Care Provided for Dependent Residents SS=D S(R(s): 483.24(a)(2)) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677	transferred to resto March she was on a her off in March she goals and was inde not meet independe When interviewed of director of nursing (services (HR) direc DON stated the res scheduled with the the monthly schedu try to have a least of scheduled daily Mo confirmed sometim staff to work on the having concerns br restorative plans no confirmed not track services were gettin R48's restorative pl there were so many therapy. DON conf by the restorative s getting done. The D not be documenting restorative sheets. available. She statt wasn't walked in Ju with a change in co why she didn't get i retire end of June s get done July and A ADL Care Provided CFR(s): 483.24(a)(2) A res	rative. From January to a program. When they took e met standing and walking pendent in sit to stand. Did ent transfers. on 8/10/18, at 3:25 p.m. the (DON) stated the human tor was in charge of staffing. torative nursing staff is day sheet and included into ale. DON further stated they one restorative nursing staff nday through Friday. DON es they had to pull restorative floor. DON further stated not ought to her related to ot getting completed. DON sing if the restorative nursing ng completed. DON reviewed an and was surprised that y "holes" in the completion of irmed she had not been told taff that programming was not DON also stated staff should g not applicable on the It should be refused or not ed I don't know why she aly. She stated she just started indition this week. I don't know t in June. We had someone to that could be why it didn't August. I for Dependent Residents 2)				9/19/18

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/11/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245558	B. WING	ì) 10/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY	- WINDOM	705 SIXTH STREET WINDOM, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	personal and oral h This REQUIREMEN by: Based on observat review, the facility fa shaving, assistance was provided for 2 of reviewed for activitie provide oral care fo reviewed for dental, staff for assistance Findings include: R4's quarterly Minin assessment dated having severely imp assessment. The N required extensive a transfers, dressing, hygiene, and exhibi symptoms toward o R4's care plan revie resident required as personal hygiene. interventions to use behaviors during ca During observation was noted to have I white hair on her ch During observation 7:16 a.m., R4 contin chin hair. Nursing a	n good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview and document ailed to ensure nail care, with eating, and oral care of 3 residents (R4, R48) es of daily living and failed to r 1 of 2 resident (R54) who was dependent upon with grooming. num Data Set (MDS) 7/27/18, identified R4 as paired cognition per staff ADS further identified R4 assistance with bed mobility, toilet use, bathing, personal ted physical behavioral thers and rejected care. ewed 8/7/18 indicated the ssistance of 1 staff with The care plan further identified if R4 was exhibiting ares. on 8/6/18, at 1:56 p.m. R4 ong soiled fingernails and long in. of morning cares on 8/8/18, at nued to have long nails and assistant (NA)-D looked at ornails and stated "oh I wish	F	677	It is the current policy and procedur GSS-Windom to provide residents w care and services to meet their need R48 has passed away. R4's nails w trimmed and facial hair was remove nursing assistant during survey. R5 oral care was completed by a nursir assistant during survey. ADL care p for R4 and R54 were reviewed and updated as appropriate by the Direct Nursing Services on Sept. 5, 2018. All dependent residents are at poter risk for this deficient practice. All dependent residents will be audited Director of Nursing Services or desi for inappropriate facial hair, nail care oral care by Sept. 19, 2018. Those with a deficit will receive services this same day. Residents who need assistance with dining will be audited Sept. 19, 2018, as well to assure pro- assistance is received by the Director Nursing Services or designee. To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursi Sept. 11-14, 2018, regarding resider grooming; including nail care, shavin and oral care, as well as assistance eating and the importance of providi these services. A random audit of grooming and	with ds. vere ed by a id's ng lans etor of ntial by the gnee, e, and found at d by oper or of t ing nt ng, with	

Facility ID: 00085

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		& MEDICAID SERVICES	(X2) MI II TI	PLE CONSTRUCTION	OMB NO.	0938-035 E SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED		
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		245558	B. WING _			10/2018		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE			
GOOD S	AMARITAN SOCIETY	- WINDOM	705 SIXTH STREET WINDOM, MN 56101					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 677	Continued From pa	age 28	F 67	7				
	pleasant and cooperative with transfers, dressing and toileting, there was no attempt to trim nails, shave chin hair or provide oral care. During observation on 8/08/18, at 2:43 p.m. R4 was observed in the dining room feeding herself an apple turnover with long dirty nails and long			assistance with eating for dep residents will be conducted b of Nursing Services or design weekly for 4 weeks, 2x's wee weeks, and then1x weekly fo Audit results will be reviewed committee with appropriate for	y the Director nee, 3x's kly for 4 r 4 weeks. by the QAPI			
	10:19 a.m., R4 con chin hair. NA-E st mood" and it was a Though R4 was ple transfers, dressing	of morning cares on 8/9/18, at tinued to have long nails and ated R4 was in a "wonderful good time to complete cares. easant and cooperative with and toileting, there was no		initiated to ensure solutions a	re sustained.			
	During interview on and NA-E confirme care, shaving, or na cares. NA-D furthe assistance with the	al cares or nail care. a 8/9/18, at 1:23 p.m. NA-D ed they had not offered oral ail trimming to R4 with morning er indicated R4 required use grooming tasks and long fingernails and chin hair.						
	registered nurse (F fingernails and chir "goatee". RN-C ind will refuse cares, h should be offered c	n 8/9/18, at 2:09 p.m. RN)-C confirmed R4 had long in hair which she described as a dicated R4 has behaviors and owever oral care and shaving daily before breakfast, and cleaned when R4 allows.						
	(DON) stated her e trim nails and provi breakfast. The DC gotten R4 a new ra would expect staff	2 p.m. director of nursing expectation is for staff to shave, de oral cares prior to N further stated she had zor about one week prior and to reapproach or complete as cooperative if refused.						

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		AND HUMAN SERVICES				FORM	: 10/11/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	E SURVEY PLETED C
		245558	B. WING _				10/2018
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			5 SIXTH STREET NDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 677	Continued From pa	age 29	F 67	77			
		d Nail Care last revised 10/17 ils clean and trimmed to					
	R54						
	identified R54 as has Mental Status (BIM impaired cognition. R54 with a diagnoss one side of the bod assistance with per R54's care plan lass self care performan hemiparesis and in dress, or groom. T R54 with several na Interventions includ personal hygiene a set up twice daily. R54's ADL care are 11/7/17 indicated e needed for all ADL' During interview on member- A stated s between R54's teet were being brushed On 8/8/18, at 7:38 a room in a Broda ch not been brushed. dry toothbrush was cabinet above the s On 8/8/18, at 9:43 a sleeping in his bed observed in the san toothbrush.	t revised 7/4/18, identified a nee deficit related to left ability to independently bathe, he care plan further identified atural teeth broken off. ded staff assistance with nd assist to brush teeth after ea assessment (CAA) dated xtensive to total assist was s due to hemiplegia. a 8/6/18, at 7:14 p.m. family she frequently notices food th and questioned if his teeth d twice daily. a.m. R54 was sitting in his iair. He indicated his teeth had An oral care basin, including a s observed in the medicine					

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CENTERS FOR MEDICARE & MEDICAID SERVICES	U	FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2	2) MULTIPLE CONSTRUCTION BUILDING	(X3) DATE SURVEY COMPLETED C
245558 В.	WING	08/10/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
 F 677 Continued From page 30 During interview on 8/8/18, at 1:31 p.m. NA-C stated oral cares are completed when getting residents up in the morning. NA-C then confirmed she had not brushed R54's teeth this morning stating she had "forgot". On 8/10/18, at 3:02 p.m. director of nursing (DON) stated her expectation is for staff to provide oral cares per plan of care. A facility policy titled Activities of Daily Living last revised 6/14, included: Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. Included in these are the following: 1. General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, applying makeup, skin , nails and oral care. R48 was admitted to the facility on 1/5/18, per the Admission Record face sheet, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain, and muscle weakness. R48's quarterly Minimum Data Set (MDS) assessment dated 6/29/18 indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. 	F 677	

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245558	B. WING _		C 08/10/2018	
	PROVIDER OR SUPPLIER	- WINDOM		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET WINDOM, MN 56101	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	LD BE	(X5) COMPLETIC DATE
F 677	resident had his ow assistance of one s cares to be perform allows. When interviewed of member (FM)-G sta seemed quite dirty is brushed his teeth. On 8/9/18, at 8:56 a and NA-H were obs cares for R48. NA's recliner where he s wheelchair (w/c) via propelled R48 into f then transferred R4 toilet. NA-D donner resident with washin hands and fingerna obtained a clean wa washed and dried F swishing his mouth NA-D asked R48 if a towel up to his mo spit. NA-D doffed f toothettes to utilize provide it. NA-D ar up and provided pe licensed practical n room and complete after pericare was of completed the treat dressing R48 and th NA-H then brought	age 31 ted 7/7/18, indicated the m teeth and required extensive staff with oral cares. Oral ned BID (twice a day) as he on 8/6/18, at 4:17 p.m. family ated feeling R48's mouth had at times and wondered if staff a.m. nursing assistants (NA)-D served providing morning s transferred R48 from the lept in the dining area, into his a standing lift. NA-H then the tub room. NA-H and NA-D 8 via the standing lift onto the d gloves and assisted the ng his face then cleaned his iils thoroughly. NA-D then ashcloth and towel and R48's underarms. R48 was as if he had food or liquid in it. he needed to spit and brought outh but the resident wouldn't ner gloves and obtained for oral care but did not nd NA-H then raised resident micare; during that time urse (LPN)-A entered the tub ed a treatment to R48's bottom completed. Once LPN-A tment, NA's then finished with ransferred him into his w/c. R48 out to the dining room for a not offered/provided oral	F 67	77		

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). 0938-039		
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED		
			A. DOILDING	۸		С		
		245558	B. WING		08/10/2018			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY	- WINDOM	705 SIXTH STREET WINDOM, MN 56101					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE		
F 677	registered nurse (R related to oral care twice a day. RN-C always try to brush toothettes. Further review of R 7/24/18, indicated t assist of one staff v resident with a calm with adequate eatin indicated R48 holds needs reminders to On 8/6/18, at 5:50 p observed seated in dining room table ir supper meal; R48's At 6:00 p.m. nursing R48 and asked him was assisting anoth at that time. NA-G was on his plate; th wrapped up in his of At 6:05 p.m., licens approached R48 to were mixed in pudo NA-G, LPN-C even the medications in p required verbal prof swallow the medicat in his mouth. The r a drink of his fluids the pudding that the R48 still had not ea assistance. The re	An 8/9/18, at 10:59 a.m. N)-C stated the expectation was as the resident allowed further confirmed staff should R48's teeth rather than using 48's care plan, last revised he resident required extensive with eating, and to provide the n, quiet setting at meal times ng time. The care plan further is liquids/food in mouth and	F 67	7				

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		E SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		/PLETED
		245558	B. WING			C / 10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00	10/2010
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 677	resident had alread that time. R48 acce approximately 50% NA-K got up from the meal in the microwa front of R48. NA-K with eating his mea- resident. At 6:55 p. with a bite of potato set it back down on observed to eat any he had been assiste When interviewed of stated R48 usually a not having any of it would check with the would check with the would eat a snack. On 8/9/18, at 9:49 a observed during his observed to prepare R48. LPN-A placed then continued to per room; LPN-A did not eating. At 9:51 a.m going to try his breat respond. LPN-A the with eating. NA-D a 10:00 a.m. as went LPN-A was also add R48 at that time. Lift medications in pudd a drink. R48 observed Name in his mouth. When	nt with eating his fruit, the y consumed all of his fluids at epted the offered food and ate of his fruit. At 6:40 p.m., ne table and heated up R48's ave then set it on the table in did not offer to assist R48 I nor offer more fluids to the m., R48 picked up his fork es on it, raised it slightly, then the plate; R48 was not of his food other than the fruit		77		

Facility ID: 00085

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			()(0)). 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED	
			A. DOILDIN	····		С	
		245558	B. WING _		08/10/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
GOOD S	AMARITAN SOCIETY	- WINDOM	705 SIXTH STREET WINDOM, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 677	his supplement into to administer media were assisting othe LPN-A approached supplement from the assist the resident of resident a drink of of accepted. LPN-A p the juice rather than mouth. LPN-A there continued to set-up At 10:26 a.m., R48 in his oatmeal; the has food/fluid conte spit some of it out a with his fingers. At the dining room and they were going to observed to take dr during the activity b himself. At 10:49 a replace NA-H on th approached R48 ar hands. NA-E askee finished eating and NA-E also asked R juice and the reside When interviewed a that sometimes R4 independently and assistance. When interviewed a confirmed R48 requires to eat. RN-0	to place his glass containing o his oatmeal; LPN-A continued cations and NA-D and NA-H er residents. At 10:21, a.m., R48, removed his glass of ne oatmeal, and attempted to with eating. LPN-A offered the orompted R48 to try to swallow n swishing it around in his n washed his hands and and administer medications. was observed with his fingers resident continued to swish ents in his mouth. R48 would at times then wiped his mouth 10:34 a.m., the pastor entered d greeted the residents stating have hymn sing. R48 was rinks of his Kemps supplement but did not attempt to feed a.m., NA-E (who had come to re unit at 10:00 a.m.), nd cleaned the oatmeal off his d the resident if he was the resident indicated he was. 48 if he wanted to finish his ent indicated that he did. at that time, NA-E confirmed					

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FATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION (X3) DA	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			MPLETED	
					С	
		245558	B. WING _	00	/10/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 677	subsequent intervie	ew on 8/10/18, at 2:41 p.m. aff on Heritage Court had a lot	F 67	7		
F 684 SS=G	CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents receir accordance with pro- practice, the compr care plan, and the r This REQUIREMEN by: Based on observat review, the facility fa services in a timely management was r (R16) who sustaine suffered harm, seve and was subsequent and ke; The facility a services were coord residents reviewed and failed to monitodor of 1 resident (R7) ref feet/ankles. Findings include: R16's Admission Ref	fundamental principle that ient and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered	F 68	It is the current policy and procedure of GSS-Windom to provide quality care to al clients. On June 22, 2018, R16's pain was controlled and continues to be sustained. R16's pain management program was reviewed and updated as appropriate by the Director of Nursing Services and the Case Manager on Aug. 17 and Sept. 6, 2018. R41's Hospice Services have beer evaluated and updated to improve coordination of care by the Administrator and Director of Nursing Services, Aug. 13-15, 2018. R7's edema treatment monitoring program was reviewed and		

Facility ID: 00085

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MEILTI	PL F (0938-039
	F CORRECTION	IDENTIFICATION NUMBER:			()	COMPLETED	
			-				
		245558	B. WING		08/10/2018		
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIET	(- WINDOM			SIXTH STREET NDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 684	Continued From pa	age 36	F 68	4			
	•	inimum Data Set (MDS)			Case Manager on Aug.16, 2018. The	е	
	assessment dated	5/18/18, indicated R16 had a		F	physician reviewed and updated her		
		Mental Status score (BIMS) of			medications on Aug. 10, 2018. Addit	tional	
		t cognition. The MDS also			monitoring began on Aug. 10, 2018.		
		ded supervision with one sistance for transfers and			All residents with pain related to falls hospice services or who have lower	oron	
		nd limited physical assistance			extremity edema are at potential risk	for	
		g in hallway and toileting. R16			this deficient practice. These resider		
		aving no pain and no falls			will be reviewed for appropriate servi		
	since prior assess				and care plans to meet their needs a		
		plan, last revised 6/18/18,			provide quality care by the Director o		
		an actual fall with minor injury			Nursing Services, Case Managers, o	or	
		nary tract infection (UTI) with ed by 2 falls on 6/16/18. The			Social Workers by Sept. 18, 2018.		
		as resident will resume usual		-	To prevent further potential deficient		
	0	urther incident. Interventions		practice, all nursing staff will be			
		ocument/report PRN (as		r	re-educated by the Director of Nursin	ng	
		hours to health care provider			Sept. 11-12, 2018, regarding pain		
		otoms) pain, bruises and			management following a fall, hospice	Э	
		ant changes in gait, mobility,			coordination, and monitoring and	0.5	
		standing/sitting balance and nt function. A care plan			treatment for lower extremity edema. Sept. 10, 2018, facility social workers		
		0/18, identified the resident had			administration, and nursing manager		
		fort R/T right ankle fracture with			are meeting with the hospice organiz		
	surgical repair.	č			to educate them on their responsibilit		
		t dated 6/16/18, at 5:40 a.m.			the deficient practice, and the new si	ign-in	
		gone into R16's room when			process being instituted.		
		ot put on her call light by 5:30			An audit of pain management needs		
		sual routine. R16 was found next to the bathroom door			every resident who sustains a fall will conducted by the Director of Nursing		
		ker next to her. The Incident			Services or designee, for 12 weeks.		
		16 had reported she didn't			audit of hospice coordination for all		
	know what had ha	ppened, but had complained of		r	residents on hospice will be conducted		
		tender to touch, but having no			the QAPI Director or designee, 1x we	eekly	
		compared to the other ankle.			for 12 weeks.		
		to bear any weight after			An audit of lower extremity edema treatment programs will be conducte	dby	
	accoccinn ind ank			- I T	\mathbf{r}		
		le however, there was no was able to move the ankle			the Director of Nursing Services or	a by	

Facility ID: 00085

If continuation sheet Page 37 of 109

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		245558	B. WING			C 10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
GOOD S	AMARITAN SOCIETY	- WINDOM				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 684	Review of an Incide 7:25 a.m. indicated bathroom by staff. wheeled R16 into th used the grab bar t indicated staff had of the room so they resident however, F the floor. The repor the fall may have by hurting from a fall 2 R16 was assisted w staff into bed. At the bed, her pain rating 1-10 with 10 indicat Nursing notes indic specimen obtained a.m. on 6/16/18 due smelling urine. Additional notes ind 6/16/18, R16 requir the left ankle, which hours as needed (F R16 had complaine A nurse's note from R16 had fallen twic described in the no had stated, "I laid th The nurse's note fu was confused beca in her bed at 3:30 a had been no calling during the night. Th unlikely R16 could night: "No tears, fla reddened areas of painful after admini	age 37 ent Report dated 6/16/18, at R16 had been assist to the The report indicated staff had ne bathroom and R16 had o stand up. The report then moved the wheelchair out d'd have room to help the R16 had suddenly slipped to t identified the root cause of een related to R16's left foot the mechanical lift and 2 e time she was transferred to g was identified as a 2 (scale of ting the worst pain). tated R16 had a urine per physician order at 7:36 e to cloudy, amber and foul dicated at 7:48 a.m. on red an ice pack for swelling to n would be provided every 4 PRN), and the notes indicated ed of pain to her left ankle. n 8:09 a.m. 6/16/18, reiterated e within 2 hours. R16 was te as "Alert but confused" and here since 10 p.m. last night". In ther indicated the resident tuse R16 had been observed a.m. during rounds, and there g out or screams from her he nurse documented it was have been on the floor all t affect, and skin had no pressureLeft ankle was still stration of PRN Tylenol 650 alled primary doctor since she	F 684	audit results will be reviewed by committee with appropriate follo initiated to ensure solutions are	ow-up	

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PLAN OF CORRECTION IDENTIFICATION NUMBER:			UPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							001	C
			5558	B. WING				/10/2018
VIDE	ER OR SUPPLIEF	3				REET ADDRESS, CITY, STATE, ZIP COD	E	
ARI	TAN SOCIET	Y - WINDOM				5 SIXTH STREET INDOM, MN 56101		
	EACH DEFICIEN	TATEMENT OF DEFIC CY MUST BE PRECED LSC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
	nued From p times 2 in la	age 38 st two hours. Us	ed mechanical	F 6	84			
t bot ood riter	th times to line up in bathro could remov	t her off the floor om, hung onto g ve the wheelchai . That sudden, s	r. Resident grab bars until ir to assist her					
owly 16/1 none	y on her butte 18, 8:13 a.m ed Dr. (docto		II in 2 hours, had fallen					
′16/1 hkle	every 4 hou	lce pack for sw rs as needed. A PRN (as needed	pply to left					
dmir urts. ′17/1	nistration wa	s effective not sv n. Due to not ab	wollen but still ble to bear full					
and eft a	times two a Inkle not swo	e after her fall, n ssist to use beds illen but is painfu rea. Call placed	side commode. I. Applied ice					
elect or an	ronic long te order to me	rm care Dr. avai dicate with PRN te indicated Acet	lable via video) Tylenol. At					
blet ote f	650 mg hac further indica	been given by r ted R16 had dis a 5 out of 10 on	nouth. The comfort in her					
ad a nkle.	n ice pack p . The note in	documentation laced due to swe cluded, "Has ice	elling of her left pack to left					
n eL ectr	TC (telemed	icine) note from re at 1:00 a.m., i 2 tablets every	6/17/18, with ncluded orders					
ain. orair ut no	The note ind ned her left a o order for pa	cluded, "Pt (patie nkle. She has a ain medication.	ent) recently an order fo rice, See order					
t 12: ad a nkle nkle ectro or tyle ain. orair ut no oove he n	:07 a.m., the in ice pack p . The note in , not swollen .TC (telemed ronic signatu enol 325 mg The note in ned her left a o order for pa e (referring to nurse's note in	documentation laced due to swe cluded, "Has ice but is very tende icine) note from re at 1:00 a.m., i 2 tablets every cluded, "Pt (patie nkle. She has a	indicated R16 elling of her left e pack to left er to touch." 6/17/18, with ncluded orders 4 hours PRN ent) recently an order fo rice, See order ' 16 continued to					

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	NG	COI	C
		245558	B. WING _			/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 684	throughout 6/17/18. th pain as an 8 out is stated the Tylenol with p.m. on 6/17/18, R1 stand on my left leg with a sit to stand lift her weight on the left or complaints, and ankle was "a little se On 6/17/18 at 9:57 had complained that bruise was noted on note indicated, "Wil Nursing notes from indicated R16 had r (acetaminophen) 65 bathroom (BR), able but says, very painf indicated ice packs ankles at 2:12 a.m. included, "Resident and can't stand on placed in the sit to si is placing most of h facial grimace or ar from the resident. I inner right foot. Sho motion) with that foo standing and bearin 'It's a little sore is al Additional notes inc 6/18/18, 6:58 a.m. given. Pain scale 9 right leg and ankle 6/18/18, 7:30 a.m. severe right leg pain	At 5:33 a.m., R16 described of 10. At 7:00 a.m., R16 vas "no help at all." At 4:15 6 stated, "I don't think I can ." However, when transferred it, the resident had put most of fit leg with no facial grimacing had denied pain but stated the ore." p.m., the notes indicated R16 it her right ankle hurt. A purple in her inner right ankle. The I continue to monitor." 6/18/18 at 2:03 a.m., eceived Tylenol 50 mg and "was gotten up to e to bear weight on both legs ul." Subsequently, notes had been applied to both At 2:16 a.m., a nurse's note states 'I hurt my right ankle my leg.' When resident is stand lift for a transfer resident her weight on that leg with no by C/O (complaints) noted Does have discoloration of teh e has full ROM (range of bit & ankle. She did fine with ing weight on both feet. States, I'." luded: Acetaminophen 650 mg . Resident stated no relief to pain. Resident complained of n, requesting analgesics. Pain scale 10. Resident	F 68	34		

Facility ID: 00085

If continuation sheet Page 40 of 109

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
			A. DOILDI			С
		245558	B. WING			/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 684	given. Resident col and ankle pain. 6/18/18, 1:36 p.m. <i>A</i> administration was resident stated not 6/18/18, 11:06 p.m. followup. Ineffective badly. 6/19/18, 12:03 a.m. right foot which now the ankle and top of two days. Rather th bed pan tonight. W 6/19/18, 5:09 a.m. to void tonight since in both feet. Now to assist to raise up of chux. Resident will much pain to move. (Acetaminophen) 65 6/19/18, 5:10 a.m. F resident needs to be mechanical lift. Note left breast. 6/19/18, 6:39 a.m. H assist out of bed wir swollen +2 and brui when transferred fre 6/19/18, 6:39 a.m.	mplained of severe right leg Acetaminophen 650 mg PRN ineffective. Pain scale 10	F 6	84		
	6/19/18, 6:39 a.m. ineffective. Pain sc rate pain severe. On 6/19/18 at 9:17 facsimile (fax) to the whether R16 should foot related to swell following her falls of physician's faxed re get an X-ray of R16	Acetaminophen 650 mg was				

Facility ID: 00085

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	· · /	TE SURVEY MPLETED C
		245558	B. WING			08	/ 10/2018
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			5 SIXTH STREET NDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
1 004	 ² 684 Continued From page 41 had been scheduled for 6/20/18 at 11:00 a.m. 6/20/19, 7:01 a.m. Acetaminophen 650 mg given. Resident complained of severe right ankle pain. 6/20/19, 8:43 a.m. Acetaminophen 650 mg. Administration was ineffective. Pain scale 8. Resident stated having no relief. 6/20/18, 12:25 p.m. Resident left at 10:45 to get right ankle x-ray. Resident left in wheelchair. 6/20/18, 3:30 p.m. Acetaminophen 650 mg given. Resident complained of moderate pain in right ankle. Requesting analgesics. 6/20/18, 4:01 p.m. Resdient arrived back at facility around 3:30 p.m. Right ankle was splinted. Pain was rated at 5. 6/21/18, 6:17 a.m. Acetaminophen 650 mg was not effective. Pain scale 8. 6/21/18, 8:15 a.m. To hospital for surgery right 		F 6				
	ankle. 6/21/18, 7:05 p.m. she had right ankle in a wheelchair. Ri wrapped with ace. medicate when me An order from eLTO identified nurse cal for pain. Patient re had an order for ico medication. At this two tablets every 4 The record further to the MD on 6/16/ had been found on	Returned from hospital where e repair about 6:30 p.m. She is ight foot is splinted and Rates pain at 8 of 10. Will eds arrive. C dated 6/17/18, at 1:00 a.m. led requesting order for Tylenol ecently sprained her left ankle, e but no order for pain s time Acetaminophen 325 mg hours PRN pain was ordered. indicated a fax had been sent 18, at 5:40 a.m. identifying R16 the floor after walking to the wheeled walker. The fax					

Facility ID: 00085

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	â	CO	MPLETED
		245558	B. WING		08	C / 10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 684	received 6/18/18, a comment, "I was ca now well. Yes?" No physician regarding ankle. Review of a pain as indicated R16 had p diagnosis or conditi non-pharmacologic and rest. The asses current medication mg and ice PRN wa X-Ray result finding 6/20/18 indicated: distal fibular fracture fracture. Allowing fo displaced facture is of the right ankle." During interview wit (DON) on 8/9/18, a should have been in more timely way rat verified no follow up medication was effet the resident's pain a ability due to the pa complaints of pain a since there was sw the DON confirmed her room with walkit the falls required tra mechanical lift and said the doctor sho fax had been reciev R16's increased pa condition. The DON called the physician	t 12:20 p.m. with physician alled about this, I assume all is preply was sent to the pain and swelling of right esessment dated 6/18/18, pain associated with a ion and identified ral interventions to include: ice ssment also identified the regimen of PRN Tylenol 650	F 684	4		

Facility ID: 00085

If continuation sheet Page 43 of 109

		& MEDICAID SERVICES	1			. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
						С
		245558	B. WING _		08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 684		ige 43 Jising on the 17th, first on the	F 68	34		
	left then on the righ addressed and add	it which should have been led, "we have pain meds in the it) we could have used to				
	make her more cor obviously not worki	nfortable since the Tylenol was ng for pain control." I6's doctor on 8/14/18, at 3:22				
	p.m. he stated he s the increased pain	hould have been notified of and swelling of the ankle. He was notified by fax of the fall				
	the morning it happ until Monday morni	ened, he did not see the fax ng 6/18/18 at which time he'd id asked if everything was "ok".				
	He stated, "I did no them until they ask	t hear anything back from ed for an X-ray on the 19th." OF HOSPICE SERVICES:				
	The facility failed to for R41.	coordinate hospice services				
	6/7/18. The form ir	ication of hospice services on ndicated hospice services had				
	diagnosis of senile R41's significant ch	ated 3/18/18, due to R41's degeneration of the brain. nange MDS dated 3/23/18,				
	and total dependen living (ADLs). The I	severely impaired cognition, ice with all activities of daily MDS also indicated R41 was				
		ervices. vised 4/3/18, indicated R41 had is related to end stage				
	Interventions incluc coping skills, conta	receiving hospice care. led: assess resident and family ct hospice staff for support as				
	maximum comfort	nursing staff to provide for the resident. Imerous papers attached was				
	observed at the numpapers was a pape	rses station. Under numerous r that said ATTENTION "[R41] is under the care of				

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245558	B. WING _		08	C / 10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
GOOD S	AMARITAN SOCIETY	- WINDOM				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 684	(name of hospice)." nurse, social worke volunteer was ident located on the clip of of hospice) nurse-w provides AM (morn Friday. Chaplain/SS (Thursday/Friday). on the second page care provided by th a hospice visit sche During observation hospice aide was p 7:43 a.m. R41 was being fed by a facili stated the hospice bath. During interview on assistant (NA)-D st [hospice staff] are g For instance, today because they had t Sometimes they giv sometimes they giv sometim	The team was identified as ar and chaplain. No aide or tified. A second page was board under that page: "(name veekly visits on Monday, Aide- ing) ADL cares Monday thru S (social service) Thurs/Fri No patient name was identified a. The hospice agency plan of e facility also failied to include edule on it. on 8/8/18, at 7:05 a.m. a resent giving R41 a bath. At sitting at the breakfast table ity staff member. The staff aide left after giving R41 her a 8/8/18, at 8:13 a.m. nursing ated, "we don't know what they going to do when they come. They couldn't feed her o go do something else. We her a bath and feed her, at feed her. We never know. s or times they will come they tell us, sometimes they re supposed to come 3 days a , but they maybe only come w what time, sometimes it's 6 supposed to be her at 8. e come at like 4 in the a 8/8/18, at 8:30 a.m. NA-F know around here when they use they have to go o they don't do everything they they can't make it they don't		84		

If continuation sheet Page 45 of 109

THEFT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(V9) DAT	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		IG		IE SURVEY MPLETED
						С
		245558	B. WING _			/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		<u>.</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 684	During interview on stated, "There is a c comes every mornin between 6 and 8 a.1 a social worker that week. The nurse co here yesterday. She comes a lot. If they they just come anot are stable so I'm no do let the nurse kno aides should be tolo During interview on practical nurse (LPI where the calendar order to know when came onto the unit stated, "The calend During observation hospice aide (HA)-A room feeding R41 are here 5 days per 5:30 a.m. because also. We have 5 diff different schedules. clients are, and who they come. If I do m and if I don't do mon breakfast, play mus bath is done so thei go because we wer we had to split visits to the staff really un ordinary. I just come	8/8/18, at 9:00 a.m. RN-C calendar at the desk. The aide ng Monday through Friday m. They have a chaplain and come in the later part of the omes on Tuesday, she was e [R41] has a volunteer that can't make it they don't tell us ther day. My hospice people t concerned about it. If they ow they aren't coming then the		34		

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	-	AND HUMAN SERVICES				FORM	APPROVED
	<u>SFOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	E CONSTRUCTION	1	0938-0391 E SURVEY
-	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245558	B. WING				C 10/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET		
				V	VINDOM, MN 56101	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 004			ı 				
F 684	Continued From pa	ge 46 to tell them we don't know	F6	84			
		re coming. That is not good					
	EDEMA MONITOR	ING					
	diagnoses of edem	ort dated 8/10/18, included a, macular degeneration (an uses vision loss), and					
	assessment dated a Brief Interview of indicating a modera MDS further indicat	num Data Set (MDS) 5/4/18, identified R7 as having Mental Status (BIMS) of "8" ately impaired cognition. The ed R7 required assistance ansfers, dressing, toilet use, ig.					
	required assistance (ADL's) related to ir weakness, and imp	ewed 5/17/18, indicated R7 with activity of daily living npaired vision, muscle aired cognition. The care s the residents bilateral nkles.					
	6/12/18, included La	ent physican orders dated asix (a medication to reduce dy) 80 milligram (MG) daily for					
	was observed to ha and ankles. The re chair in her room w The resident had ve socks on, however to R7's ankles from	on 8/8/18, at 12:50 p.m., R7 we bilateral edema in her feet sident was sitting in a recliner ith her feet resting on the floor. elcro closing shoes and grippy there was visible indentation the grippy socks. The right ddened appearance.					

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PRINTED: 10/11/2018

		AND HUMAN SERVICES				FORM	APPROVED
	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MU	тір			0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(C
		245558	B. WING			08/	10/2018
NAME OF F	PROVIDER OR SUPPLIER			0,	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET		
					WINDOM, MN 56101		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		DATE
	1		l.				
F 684	Continued From pa	ao 47	ГС	0.4	4		
1 004	Continued From pa	ge 47	F 6	084	*		
	During observation	on 8/9/18, at 8:46 a.m.					
	nursing assistant (N	IA)-C transferred R7 into a					
		was wearing socks and shoes,					
		teral edema to ankles was remained on the floor when					
	NA-C left the room.						
		8/8/18, at 10:04 a.m. NA-C					
		edematous ankles. NA-C					
		were no specific interventions ndicated R7 would elevate her					
	feet if she wanted to						
	5 · · · ·						
		8/8/18, at 1:09 p.m. N)-B indicated R7 had long					
		her lower extremities. RN-B					
	confirmed there wa	s no formal monitoring in					
	place for the edema	a.					
	During observation	and interview on 8/9/18, at					
		sitting in her recliner chair with					
		ind. RN-C assessed R7's					
		ating they were cool and dry.					
		d right lower extremity had a					
		t no warmth or discomfort -C identified R7 had two plus					
		ling that is significant enough					
		ation of 3-4 millimeters deep in					
		essed with a finger) in right					
		one plus pitting edema					
		llimeters) in left ankle and R7 had refused to wear					
		n the past, however indicated					
	R7 should have oth	er interventions in place to					
		or the edema, confirming there					
	was nothing in plac	e at this time.					
	During interview on	8/10/18, at 2:48 p.m. the					

Facility ID: 00085

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PRINTED: 10/11/2018

TATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3 NO. 0938-039 3) DATE SURVEY COMPLETED	
		245558	B. WING		C 08/10/2018	
	PROVIDER OR SUPPLIER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 684 F 686 SS=G	director of nursing extremity edema sl interventions in pla A facility policy titler indicated each resi individualized, pers plan of care that wi and timetables dire maintaining the res nursing, physical, fi psychosocial and e use of departmenta Assessment Instru physician's orders, concerns identified Treatment/Svcs to CFR(s): 483.25(b)(1) §483.25(b)(1) Pres Based on the comp resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the ir demonstrates that (ii) A resident with p necessary treatment with professional standa promote healing, p new ulcers from de This REQUIREME by: Based on observa	(DON) confirmed R7's lower hould be monitored with ce to control it. d Care Plan revised 11/16, dent will have an con-centered, comprehensive Il include measurable goals acted toward achieving and ident's optimal medical, unctional, spiritual, emotional, educational needs. Through al assessments, the Resident ment and review of the any problems, needs and will be addressed. Prevent/Heal Pressure Ulcer 1)(i)(ii) regrity sure ulcers. orehensive assessment of a <i>r</i> must ensure that- ves care, consistent with ards of practice, to prevent d does not develop pressure ndividual's clinical condition they were unavoidable; and oressure ulcers receives nt and services, consistent tandards of practice, to revent infection and prevent	F 684	It is the current policy and procedure GSS-Windom to assess and provide	of	

Facility ID: 00085

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	-	AND HUMAN SERVICES				FORM	10/11/2018 APPROVEE <u>0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (COMF	SURVEY PLETED
		245558	B. WING			(0 8 /1	, 0/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET /INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETIOI DATE
F 686		of 1 resident (R48) with two	F 6	86	at risk for pressure sores.		
	This deficient pract R48 when one stag and a new stage 2 Findings include: R48's Admission Re R48 had been adm with diagnoses includementia, atrial fibr muscle weakness. R48's quarterly Min assessment dated severe cognitive im dependent on staff and required extens mobility, transfers, o personal hygiene. R48 was frequently bladder, was at risk utilized a pressure	ired stage 2 pressure ulcers. ice resulted in actual harm for ge 2 pressure ulcer worsened pressure ulcer developed. ecord Face Sheet, indicated itted to the facility on 1/5/18, uding: Parkinson's disease, illation, heart failure, pain and imum Data Set (MDS) 6/29/18, indicated R48 had pairment, was totally with locomotion on/off the unit, sive assistance with bed dressing, eating, toilet use and The MDS further indicated incontinent of bowel and a for pressure ulcers, and relieving device in bed and			R48 was assessed and provided wit interventions for pressure sores the of survey by the Case Manager and Director of Nursing Services. R48 h since passed away. All residents with pressure sores are potential risk for this deficient practic These residents will be assessed wir appropriate interventions put in place appropriate by Sept. 18, 2018 by the Managers and Director of Nursing Services. To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursin Sept. 11-14, 2018, regarding comprehensive assessment of and t implementation of appropriate interventions for preventing and treat pressure sores.	week as e at ce. th e as e Case	
	included: The residulcer development with mobility and free The interventions in mattress and cushi nurse immediately breakdown; redness discoloration, etc. n	R48's current care plan, last revised 7/24/18, included: The resident has potential for pressure ulcer development R/T (related to) needs assist with mobility and frequent bladder incontinence. The interventions included: Pressure reduction mattress and cushion in w/c (wheelchair). Notify nurse immediately of any new areas of skin breakdown; redness, blisters, bruises, discoloration, etc. noted during bath or daily care.			An audit of pressure sore assessme and interventions for each resident v pressure sore will be conducted by t Director of Nursing Services or desig 1x weekly for 13 weeks. Audit results be reviewed by the QAPI committee appropriate follow-up initiated to ensist solutions are sustained.	with a the gnee, ts will with	
	dated 6/28/18, indic	Support Data Collection Tool cated the resident had enough aintain an upright, seated					

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II 7	TIPLE CONSTRUCTION). 0938-039 FE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG		MPLETED
						С
		245558	B. WING			/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 686	position, used a sit- staff when transferr required assist of tw ambulation. The da support R48 needer bed from side-to-sic sitting on the edge of seated position on the reclined position on the reclined position in the Does not sleep in a R48's quarterly Bray Pressure Sore Risk 13, indicating R48 w breakdown. In addit Observation form d skin conditions obset On 8/8/18, R48 was 7:15 a.m. until 9:38 dining area. Staff w in and out of the dir breakfast during that the footrest of the re- hanging down with R48 would move his make moaning/hum a.m., nursing assist and asked if he was responded he was. transferred R48 into had a pressure reducing of then propelled R48 to the toilet. NA-D in had completed R48 had assisted R48 to	to-stand lift with assist of two ing between surfaces, and vo staff with a walker for ata did not indicate what d to position up in bed, turn in de, to move from lying to of bed, or to move from a he side of the bed to a lying or bed. The data indicated: bed. den Scale for Predicting dated 6/28/18 was scored as vas at moderate risk for skin ion, R48's recent Skin ated 8/5/18, indicated: no	F 6	86		

Facility ID: 00085

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION	(X3) DA). 0938-039 FE SURVEY MPLETED
		245558	B. WING		C 08/10/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10,2010
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 686	NA-F were observe toilet. When R48 w and NA-F stood the peri-care. R48's bo small open red area on the right upper b areas were circular centimeters (cm) in areas were new, NA her. The NAs then s onto the toilet and a the tub room to obs Licensed practical r room and confirmed bottom. LPN-B stat but that she would k medical record to m there prior to today. NA's to feed the res providing treatment When interviewed in observation, NA-D of the recliner in the di the resident first can attempt to have him room as the resider home however, NA- of the recliner in his recliner in the dining per R48's preference sleep in the recliner When interviewed of stated staff try to re though sometimes first can stated sometimes first can be bound the recliner in the dining per R48's preferences	d to transfer R48 onto the ras finished on the toilet, NA-D resident up to provide stom was observed to have 2 as, one on the coccyx and one outtock near the crease; the and approximately 0.5 diameter. When asked if the A-D stated they were new to sat the resident back down alerted the nurse to come into erve the resident's bottom. hurse (LPN)-B entered the tub d R48 had 2 open areas on his ted the areas were new to her have to research the resident's hake sure they had not been LPN-B then instructed the sident breakfast first prior to or measuring the open areas. mmediately following the confirmed R48 always slept in ining area. NA-D stated when me to the facility they would n sleep in the recliner at -D stated R48 would crawl out a room and come out to the g area to sleep. NA-D stated be, they continued to have him	F 6			

Facility ID: 00085

If continuation sheet Page 52 of 109

		AND HUMAN SERVICES				FORM	: 10/11/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245558	B. WING				C 10/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		-	05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 686	A facsimile (Fax) to 8/8/18, and sent at has an open area o an order to read Hy Change q (every) 5 dislodged or soiled. physician, dated 8/8 reviewed with physi On 8/8/18, at 1:10 p in the recliner in the bent and eyes close time NA-D confirme transferred into the 12:50 p.m. NA-D fu not yet measured o to the open areas o awaiting direction fr manager (RN)-C. When interviewed o stated she had app the open area on R the dressing was la smaller superficial r coccyx as well. Wr open area on R48's stated not realizing one open area. LP back to work tomor it then. LPN-B confi the open area on R having a difficult tim standing during the open area on the co	age 52 9 R48's physician dated 11:34 a.m. indicated: "[R48] on his coccyx. May we have verocolloid to open area. 6 days or when it becomes ." A fax response from the 9/18 at 10:07 a.m., was ician approval of this plan. o.m. R48 was observed laying e dining room with his knees ed. When interviewed at that ed the resident had been recliner at approximately urther confirmed LPN-B had or done any type of treatment on R48's bottom as she was rom the registered nurse case on 8/8/18, at 1:57 p.m. LPN-B blied a hydrocolloid dressing to 48's coccyx. LPN-B stated arge enough to cover the reddish areas below the hen asked about the other a right upper buttock, LPN-B the resident had more than N-B then stated she would be row morning and could look at firmed she had not measured 48's coccyx as staff was he keeping the resident t treatment. LPN-B stated the occyx was approximately 0.5 ter. LPN-B confirmed R48 had ssure reducing cushion when	F 6	86			

If continuation sheet Page 53 of 109

ATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED C 08/10/201	
		245558	B. WING			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ	
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 686	On 8/9/18, at 8:56 a observed getting R4 perform morning ca standing lift (a mech into his w/c. R48's waffle air cushion of the cushion; the rec reducing cushion of propelled into the tu assisted with cares to transfer the resid removed R48's brie movement. NA-D a duoderm dressing of NA-H informed her R48 with washing u day, NA-D and NA- to a standing positio peri-care. R48 holl bottom was being of observed; there wa resident's coccyx. If the coccyx, an upper was new since the lower open area on white slough coveri on the right upper b decreased in size, y to be closed, there area next to it. NA's the nurse. LPN-A e measured the open new upper area on and was circular, th 1.8 cm x (by) 1.0 cr small reddened are though felt they wer	a.m. NA-H and NA-D were 48 up out of his recliner to ares. The NA's utilized a hancical lift) to transfer R48 w/c had a pressure reducing n the seat with very little air in cliner did not have a pressure n the seat. R48 was then ab room to be toileted and . NA's utilized the standing lift ent onto the toilet, NA-H of, which was soiled with bowel asked NA-H if there was a on the resident's bottom and there was not. After assisting p and changing clothes for the H then raised the resident up on with the lift and provided ered out "Ow!" while his leansed. R48's bottom was s no dressing covering the R48 had two open areas on er open area on the coccyx observation on 8/8/18. The the coccyx was larger with ng the wound bed. The area outtock near the crease had was reddened and appeared was another small reddened s put the call light on to alert entered the room and area's on R48's coccyx. The the coccyx measured 1.0 cm e lower open area measured n. LPN-A also identified the as on R48's right buttock re scratches. LPN-A applied coccyx then covered the open	F 68	6		

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		AND HUMAN SERVICES				FORM	: 10/11/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245558	B. WING				C 1 0/2018
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	finished dressing R dining room for breat When interviewed of stated R48 was to be just like all the other When interviewed of stated he was told w that RN-C wanted h R48's bottom as it h an open area. LPN were no new interve any further reports she'd (RN-C) take i When interviewed of stated LPN-B had r area on the coccyx area due to the rest though was able to duoderm dressing. updated R48's care was to be reposition after meals, for the afternoon, and at H that would be appro R48 allowed. RN-C usually wait until R4 ready to get up befor further stated staff of resistive, they let hi they'd be implement cushion to be utilized the recliner as well to this a pressure re utilized in R48's reco	48 and transported him to the akfast. on 8/9/18, at 10:49 a.m. NA-E be repositioned every 2 hours r residents on the unit. on 8/9/18, at 10:55 a.m. LPN-A when coming on duty today him to take a good look at had been reported there was I-A stated other than that there entions to inform RN-C of, or of what he'd observed, but that	F	586			

Facility ID: 00085

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/11/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	COM	E SURVEY PLETED C
		245558	B. WING	à			10/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		-	705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 686	should have been u night and was not s further confirmed a been applied when fallen off. RN-C sta for when the pressu deflating and/or nee LPN-A was usually worked as a restora When interviewed of confirmed R48's pro- cushion was on the needed more air in nursing's responsib and make sure they LPN-A also stated w 2:30 p.m. he would down to therapy to have staff pick up a resident's recliner. Review of the Woun 8/9/18 by LPN-A ide the coccyx as mois When interviewed of 10:00 a.m. RN-C co visualized R48's op could not say for su associated or press confirmed an RN ha areas. During observation RN-C and the direc confirmed R48 had	tilized in R48's recliner last ure why it was not. RN-C new dressing should have R48's previous dressing had ated staff should be monitoring ure reducing air cushions were eded more air. RN-C stated the one to do this as he also ative therapy nurse. on 8/9/18, at 1:48 p.m. LPN-A essure reducing waffle air low side and definitely it. LPN-A stated it was ility to monitor the cushions y were inflated adequately. when the next shift came on at have them take the cushion be inflated and would also in extra cushion to keep in the nd Data Collection dated entified R48's open areas on ture associated wounds. on 8/10/18, at approximately onfirmed she had not yet en areas on the coccyx and are if they were moisture sure wounds. RN-C further ad not assessed R48's open	F	686			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE	PLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				IPLETED
						С
		245558	B. WING		08/	/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 686	DON provided doci were to follow when discovered. The DO staff to notify the R and to fax the phys DON stated the RN evaluate the area a and to provide the a interventions. Whe Mobilization Suppo 6/28/18, she stated R48 as he did not a seat much of the til looked at a little dif The DON also com Assessment and E completed for R48 repositioning scheo stopped utilizing his have been updated expected a pressur utilized in the reclin repositioning, she v R48 slept and what go from there. She with every hour and reposition at night i would depend upor had pressure mapp therapy but confirm completed for R42.	age 56 on 8/10/18, at 10:54 a.m. the umentation of the process staff in a new skin issue was ON stated she would expect N case manager right away sician of the skin issue. The N case manager should as soon as she could to assess appropriate treatment and en the DON reviewed R48's ort Data Collection Tool dated a the tool did not fully apply to sleep in bed and was on his me therefore should have been ferently in terms of positioning. firmed a Positioning valuation had not been to determine an individualized dule, and added when R48 s bed, the care plan should d, and she would have re reducing cushion to be her. The DON stated with would need to see how well t that pattern looked like and e stated she would've started d a half to 2 hours for a dule. As far as how often to f the resident was sleeping in if he had a good cushion and bing completed by physical ned that had not yet been . DON confirmed staff should he appropriate amount of air in	F 686	5		

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		& MEDICAID SERVICES				0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	LE CONSTRUCTION		TE SURVEY MPLETED
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		245558	B. WING		08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 686	Continued From pa	age 57	F 686			
	can see them on th communication wri					
	Ulcer Prevention au Requirements revis Residents who are themselves indepe Mobilization Suppo should be repositio care plan approach individualized reposition for those residents and is based on nu diagnoses, mobility resident's skin over Positioning Assess required tool that is individualized reposition pressure ulcer is id to observations bei bed and depth to b The registered nurs	sed 4/16 included: 6. unable to reposition ndently, as indicated on the rt Data Collection Tool UDA, ned as often as directed by the				
	Wound RN Assess ulcer, record the st records the location measurements and characteristics. Do Wound Data Collect	ment UDA (i.e., for a pressure age). The licensed nurse n of the area, the	F 698			9/19/18

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		AND HUMAN SERVICES			FORM	10/11/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		245558	B. WING			C 10/2018	
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	705 SIXTH STREET WINDOM, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 698	Continued From pa	ige 58	F 698				
	require dialysis reco with professional st comprehensive per the residents' goals This REQUIREMEN by: Based on interview facility failed to obta the dialysis provide residents (R20) rev the potential to affe dialysis treatments Findings include: R20's face sheet da admission date of 2 included diagnoses and dependence or R20's quarterly Min 5/25/18, identified F Review of R20's ph included an order fo Wednesday, and Fi a.m. R20's care plan las dialysis care. On 8/10/18, at 10:5 stated the facility di current written agree for coordination of s	asure that residents who eive such services, consistent andards of practice, the son-centered care plan, and and preferences. NT is not met as evidenced v and document review the ain a written contract between r and the facility for 1 of 1 iewed for dialysis. This had ct all residents who received and resided at the facility. ated 8/10/18, identified an 2/22/18. The face sheet of end stage renal disease in renal dialysis. himum Data Set (MDS) dated R20 received dialysis.		It is the current policy and procedu GSS-Windom to provide coordinat dialysis care. R20 passed away. No other residents receive dialysis services. If a new client comes on dialysis services from a different cl than our contracted one, we will ini contract with that clinic as well. On Aug 13, 2018, the administrator contract to the dialysis clinic and is awaiting review of the contract by t clinic. This will assure coordination for future residents on dialysis serv When the contract is received, the committee will be notified. If appro the contract auto-renews after 1 ye QAPI committee will review the cor August 2019.	inic tiate a r sent a of care vices. QAPI priate, ear. The		

Facility ID: 00085

If continuation sheet Page 59 of 109

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245558	B. WING _		C 08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 698	as there was no bill been admitted to the for dialysis. The ad had residents in the treatments but it hat The Dialysis Service identified locations dialysis services mi place with the provi	ling involved and R20 had be facility already going there ministrator stated the facility e past who required dialysis ad been several years. These policy revised 1/18, caring for residents receiving ust have an agreement in ider of the service.	F 69			
F 725 SS=F	CFR(s): 483.35(a)(§483.35(a) Sufficie The facility must ha the appropriate cor provide nursing and resident safety and practicable physica well-being of each resident assessme and considering the diagnoses of the fa accordance with the at §483.35(a)(1) The by sufficient number	1)(2) nt Staff. ave sufficient nursing staff with npetencies and skills sets to d related services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by nts and individual plans of care e number, acuity and cility's resident population in e facility assessment required facility must provide services ers of each of the following	F 72			9/19/18
	types of personnel nursing care to all r resident care plans (i) Except when wa this section, license (ii) Other nursing po limited to nurse aid §483.35(a)(2) Exce	on a 24-hour basis to provide esidents in accordance with : ived under paragraph (e) of ed nurses; and ersonnel, including but not				

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TATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245558	B. WING _		(08/ ⁻	C 1 0/2018
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
good s	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 725	Continued From pa	age 60	F 72	25		
	nurse on each tour	ed nurse to serve as a charge ^r of duty. NT is not met as evidenced				
	review the facility f nursing staff to pro- needs for 1 of 4 re pressure ulcers, , for hospice, 1 of 5 accidents, 1 of 1 re edema, 3 of 3 resid for activities of dail resident (R39) revi addition, 3 of 3 resid family members (F members (RN-C, L NA-I) voiced conce nursing staff in the nursing staff had th	ation, interview and document ailed to provide sufficient ovide and meet assessed sidents (R48) reviewed for 1 of 1 resident (R41) reviewed residents (R16) reviewed for dents (R4, R48, R54) reviewed y living (ADLs), and 1 of 1 ewed for position mobility. In idents (R16, R39, R58), 1 of 3 FM-G), and 6 of 6 staff _PN-A, TMA-A, NA-D, NA-H, erns with the lack of sufficient facility. The lack of sufficient facility. The lack of sufficient and the potential to affect all 70 cility along with visitors and		It is the current policy a GSS-Windom to provide staff to assure resident s attain the highest practic mental and psychosocia each resident. R48 (FM-G) has passed hospice staffing coordin hospice care has been r updated with the hospic pain management regim reviewed and updated. I treatment monitoring pro reviewed and updated a R48, and R54's ADL new regarding assistance an necessary. R39's restor was reviewed and updat R58, R39, and R16 will bowel and bladder asse be reviewed and used to plan by Sept. 19, 2018.	e sufficient nursing safety and to cal physical, il well-being of d away. The ation of R41's reviewed and e company. R16's ne has been R7's edema ogram has been s needed. R4, eds were reviewed d updated as rative program ted as necessary. receive a 72-hour ssment, which will o update the care	
	Pressure Ulcers:	rehensively assessed and		and patterns on the 500 analyzed and re-organiz the resident needs.	-wing have been	
	pressure relieving implemented. On observed from 7:13 recliner in the dinir other residents in a providing breakfas one leg on the foot	interventions were not 8/8/18, R48 was continuously 5 a.m. until 9:38 a.m. lying in a ng area. Staff were assisting and out of the dining room and t during that time. R48 had rest of the recliner with the down with one shoe off and one		All other resident needs. All other residents are a this deficient practice. A residents will be conduc 2018, to determine if res 200-wing and 400-wing sufficient staff to meet th services they need. If tr of concerns are found, f	A random audit of ted by Sept. 19, sidents on the feel there is ne care and ends or patterns	

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	-	PLETED	
		245558	B. WING			C 08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		00/10/2010	
good s	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCEI	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIC DATE	
F 725	up; the resident res NA-F pivot transfer (w/c) which had a p cushion on the seat not have a pressure seat. NA-D then pr to be toileted. NA-E (NA-J) had already cares earlier when 6:00 a.m. (approxin NA-D and NA-F tra Once R48 was finis NA-F stood the resi R48's bottom was of red areas, one on the upper buttock near circular and approx in diameter. When NA-D indicated they sat the resident back alerted the nurse to observe the resider nurse (LPN)-B ente confirmed R48 had LPN-B stated the au would have to resear record to make sure to today. LPN-B the the resident breakfat treatment or measu interviewed immedi observation, NA-D the recliner in the d the resident first cal	ig assistant (NA)-D ad asked if he was ready to get ponded he was. NA-D and red R48 into his wheelchair ressure reducing waffle air t. The resident's recliner did e reducing cushion on the opelled R48 into the tub room D indicated the night aide completed R48's morning assisted with toileting around nately 3 1/2 hours earlier). Insferred R48 onto the toilet. hed with toileting, NA-D and dent up to provide peri-care. observed to have 2 small open ne coccyx and one on the right the crease; the areas were imately 0.5 centimeters (cm) asked if the areas were new, y were new to her. NA's then the down onto the toilet and come into the tub room to nt's bottom. Licensed practical red the tub room and 2 open areas on his bottom. reas were new to her but arch the resident's medical e they had not been there prior en instructed the NA's to feed ast first prior to providing uring the open areas. When	F 7	On Sept.11-14, 2018 be educated by the I Services and Admin staffing patterns and 2018, all other staff the Administrator an on the new staffing p Sept. 1-Oct. 26, 201 random audits will b QAPI Director or des residents and familie staff to provide the o need. Audit results	istrator on the new I duties. On Sept. 17, will be educated by d Management Team batterns and duties. 8, a total of 30 e completed by the signee, asking es if there is sufficient are and services they will be reviewed by		

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA) <u>. 0938-039</u> TE SURVEY MPLETED	
		245558	B. WING		08	C 08/10/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		/10/2010	
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 725	and come out to the sleep. Per R48's p have him sleep in th When interviewed of stated staff try to re- though sometimes stated sometimes stated sometimes to being reposition and the move. Fax to physician da a.m. indicated: Hat May we have an or- open area. Change becomes dislodged to the facility 8/9/18 approval of the orde On 8/8/18, at 1:10 p in recliner in the dir eyes closed. When confirmed the resid recliner at approxin confirmed LPN-B h any type of treatme bottom as was awa registered nurse ca When interviewed of stated she had app the open area on R4 the dressing was la smaller superficial fictorics one open area. LP	e recliner in the dining area to reference, they continued to he recliner in the dining area. on 8/8/18, at 10:27 a.m. NA-D position R48 every 2 hours it can be longer. NA-D further he resident was resistive to d other days he was up and on ted 8/8/18, and sent at 11:34 s an open area on his coccyx. der to read Hydrocolloid to e q (every) 5 days or when it d or soiled. Fax was returned at 10:07 a.m. with physician					

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		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED	
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		245558	B. WING _		08/	10/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	705 SIXTH STREET WINDOM, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 725	the open area on R having a difficult tim standing during the open area on the co cm round in diamet never utilized a pre- in the recliner. On 8/9/18, at 8:56 a observed getting R- perform morning ca standing lift to trans w/c had a pressure the seat with very li recliner did not hav on the seat. R48 w room to be toileted utilized the standing onto the toilet, NA-F was soiled with bow NA-H if there was a resident's bottom a was not. After assi changing clothes for then raised the resi with the lift and pro- out "Ow!" while his R48's bottom was co dressing covering ti two open areas on area on the coccyx observation on 8/8/ the coccyx was larg the wound bed. Th buttock near the cre was reddened and was another small	firmed she had not measured tables coccyx as staff was ne keeping the resident treatment. LPN-B stated the occyx was approximately 0.5 ter. LPN-B confirmed R48 had ssure reducing cushion when a.m. NA-H and NA-D were 48 up out of his recliner to ares. The NA's utilized a sfer R48 into his w/c. R48's reducing waffle air cushion on ttle air in the cushion; the e a pressure reducing cushion /as then propelled into the tub and assisted with cares. NA's g lift to transfer the resident H removed R48's brief, which wel movement. NA-D asked a duoderm dressing on the nd NA-H informed her there sting R48 with washing up and or the day, NA-D and NA-H ident up to a standing position vided peri-care. R48 hollered bottom was being cleansed. observed; there was no he resident's coccyx. R48 had the coccyx, the upper open	F 72				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245558	B. WING		08	C / 10/2018
	PROVIDER OR SUPPLIER	- WINDOM		CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	WINDOM, MN 56101 PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 725	on R48's coccyx. The coccyx measured for the coccyx measured for the coccyx measured for the coccyx then covered by the covere	nd measured the open area's The new upper area on the 1.0 cm and was circular, the easured 1.8 cm x (by) 1.0 cm. ed the small reddened areas ock though felt they were applied skin prep to R48's ed the open areas with a ng. NA-H then finished ransported him to the dining	F 7	725		

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		AND HUMAN SERVICES			FORM	: 10/11/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY IPLETED
		245558	B. WING			C 10/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	was resistive, they I also implementing F cushion to be utilized the recliner as well to this a pressure re- utilized in R48's rec- necessary as the re- RN-C confirmed the should have been u- night and was not s further confirmed R been replaced when should be monitorin air cushions were d RN-C stated LPN-A as he also worked a When interviewed of confirmed R48's pre- cushion was on the needed more air in nursing's responsib and make sure they LPN stated when the p.m. he would have to therapy to be infla- cushion to keep in t Review of the Woun 8/9/18 by LPN-A ide the coccyx as moist When interviewed of 10:00 a.m. RN-C co- visualized R48's op could not say for su associated or press	Ige 65 let him sleep. RN-C stated R48's pressure reducing ed when the resident was in as the w/c. RN-C stated prior educing cushion had not been cliner as did not think it ecliner cushion was soft. e pressure reducing cushion utilized in R48's recliner last sure why it was not. RN-C 48's dressing should have in the old fell off and that staff ing when the pressure reducing leflating and needed more air. A was usually the one to do this as a restorative therapy nurse. In 8/9/18, at 1:48 p.m. LPN-A essure reducing waffle air low side and definitely it. LPN-A stated it was were inflated adequately. The next shift came on at 2:30 them take the cushion down ated and to pick up an extra the resident's recliner. Ind Data Collection dated entified R48's open areas on ture associated wounds. In 8/10/18, at approximately ponfirmed she had not yet then areas on the coccyx and ure if they were moisture sure wounds. RN-C further ad not assessed R48's open	F 725			

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	RS FOR MEDICARE				OMB NC		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED	
			A. DOILDING	۸		С	
		245558	B. WING		08/10/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 725	During observation RN-C and the direct confirmed R48 had on his coccyx and a the inner right butto When interviewed of DON provided doct were to follow wher discovered. DON s to notify the RN cas fax the physician of the RN case manag as soon as she cou- the appropriate trea DON reviewed R48 Collection Tool date of the tool did not a sleep in bed and wa time therefore shou differently in terms confirmed a Positio Evaluation had not determine an indivisi schedule. DON co- utilized his bed the updated and would reducing cushion to DON stated with re how well R48 slept like and go from the every hour and a ha far as how often to resident was sleepi had a good cushior	on 8/10/18, at 10:38 a.m. stor of nursing (DON) two stage 2 pressure ulcers a small 0.5 cm open area on ock. on 8/10/18, at 10:54 a.m. the umentation of the process staff n a new skin issue was stated she would expect staff se manager right away and to i the skin issue. DON stated ger should evaluate the area uld to assess and to provide atment and interventions. I's Mobilization Support Data ed 6/28/18. DON stated much pply to R48 as he did not as on his seat much of the uld have been looked at a little of positioning. DON ming Assessment and been completed for R48 to dualized repositioning nfirmed when R48 no longer care plan should have been have expected a pressure o be utilized in the recliner. positioning would need to see and what that pattern looked ere, though would start with alf to 2 hours repositioning. As reposition at night if the ing would depend upon if he n and had pressure mapping ical therapy. DON confirmed	F 725	5			

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			0	FORM MB NO.	10/11/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			COM	E SURVEY PLETED C
		245558	B. WING				- 10/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	utilizing. DON conf completed an asset first identified. DON interventions for res plan and it will com- transfer to the kard on the kiosk - there written at the station the NA's should hav in his recliner once plan. SEE F686 FOR AD Pain Management R16 was not provid timely manner to tr fall that resulted in a incident report date identified staff went knocking since resi 5:30 a.m. as per us the floor next to the Walker next to her. what happened. Le more swollen than bear any weight afte bruising, able to mo and down. Review of incident f a.m. identified resic bathroom as she ha wheeled R16 into th grab bar to stand up out of the room so f suddenly let self slip	Ige 67 irrmed an RN should have ssment on the wound when N stated when there are new sidents' it will go on the care e out with a "k" and that will ex so the NA's can see them was also a 24 communication in for staff as well. DON stated ve known to utilize the cushion implemented into the care DITIONAL INFORMATION ed care and services in a reat an injury resulting from a a fractured ankle. Review of d 6/16/18, at 5:40 a.m. into R16's room after dent did not put on call light at sual. R16 was found sitting on e bathroom door frame. R16 stated she didn't know eft foot tender to touch, no other ankle. R16 not able to er assessing ankle, no ove ankle back and forth, up report dated 6/16/18, at 7:25 dent was taken to the ad her call light on. Staff he bathroom. R16 used the p. Staff moved the wheelchair to help resident. Resident p to the floor. The fall was port also identified the root	F	725			

Facility ID: 00085

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		& MEDICAID SERVICES	1		OMB NO.	APPROVE 0938-039
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
			A. BOILDI			С
		245558	B. WING _		08/	10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 725	cause of the fall ma foot was hurting sin earlier. R16 was as and 2 staff onto bee as 2. Review of nursing r 6/16/18, 7:36 a.m. and sent to WAH (k analysis) per Dr's o amber, foul smell. 6/16/18, 7:48 a.m. ankle, every 4 hour for swelling. Having 6/16/18, 8:09 a.m. hours. Alert but con since 10 p.m. last n a.m. as was checked were no screams con that there was no o night. No tears, flat reddened areas of p painful after admini mg. Called primary urine is very foul and in last two hours. U to lift her off the flood bathroom, hung on remove the wheelch toilet. That sudden buttocks. 6/16/18, 8:13 a.m. A phoned Dr. to inforr ankle, no swelling a	ay have been that R16's left ice she had fallen 2 hours ssisted with the mechanical lift d. Pain rating was identified notes are as follows: Urine specimen was obtained ocal hospital) for U/A (urine rder. Urine is cloudy and Ice pack for swelling to left s as needed apply to left ankle	F 72			

STATEMENT	T OF DEFICIENCIES OF CORRECTION	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DA). 0938-039 TE SURVEY MPLETED	
		245558	A. BUILDI		C 08/10/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 725	6/16/18, 8:15 a.m., ankle and was broubreakfast. Has no addresses tablema 6/16/18, 9:06 a.m. ankle every 4 hours ankle for swelling F administration was hurts. 6/16/18, 11:02 a.m. regarding UA, orde given one dose it wallergy, call MD informedication. He statistication was shouldn't be a probin changed to Macrobin days. 6/17/18, 12:02 a.m. weight on left ankle stand times two asses Left ankle not swoll pack to affected are (electronic long terrifor an order to med 6/17/18, 12:04 a.m. mg give by mouth epain. Acetaminoph per day. Contact pinters ankle, every 4 hour left ankle, not swoll 6/17/18, 12:07 a.m. ankle, every 4 hour left ankle, not swoll 6/17/18, 12:14 a.m. pain in left ankle. Cfalls 6/16/18. Spok	Applied ice pack to left outer ught to dining room for complaints of pain while te's at breakfast. Ice pack for swelling to left s as needed. Apply to left	F 7				

If continuation sheet Page 70 of 109

DEPART	MENT OF HEALTH	AND HUMAN SERVICES	P		APPROVED		
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	СОМ	E SURVEY PLETED
		245558	B. WING				C 10/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	Continued From pa 6/17/18, 1:23 a.m. and effective. Follow 6/17/18, 2:32 a.m. I ankle. 6/17/18, 3:29 a.m. I edge of bed as write resident to rate her said feels better tha weight on affected I to stand to bathroor 6/17/18, Acetamino general aches. 6/17/18, 5:33 a. m. ankle. Rates the pa 6/17/18, 6;05 a.m. it feels the same. 6/17/18, 7:00 a.m. administration was "no help at all." 6/17/18, 4:15 p.m. can stand on my lef	age 70 Acetaminophen was given w up pain score 5. Ice pack for swelling to left Resident was sitting up on er (staff) went by. Asked pain, stated it's better now, an yesterday. Able to bear full left foot. Transferred with sit	1	725	DEFICIENCY)		
	stated it's a little sol 6/17/18, 9:57 p.m. I hurt. Noted a purpl Will continue to mo	Resident stated right ankle le bruise on inner right ankle. nitor.					
		Acetaminophen 650 mg given. e to bear weight on both legs nful."					

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		AND HUMAN SERVICES				FORM	APPROVED	
		& MEDICAID SERVICES	1				0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(-)	E SURVEY PLETED	
			A. DOILD			(С	
		245558	B. WING				10/2018	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET			
GOOD S	AMARITAN SOCIETY	- WINDOM						
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	-	VINDOM, MN 56101 PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX TAG			PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D TO THE APPROPRIATE DATE DATE		
F 725	Continued From pa	ge 71	F7	725				
	6/18/18, 2:12 a.m. ankles.	Ice pack applied to both						
	annies.							
		Stated "i hurt my right ankle my leg". When placed in sit to						
		r placed most of weight on						
		al grimace or complaints. Has inner right foot. Stated its a						
	little sore scant swe							
	6/18/18, 2:48 a.m. ankle. Took the pat	Ice pack for swelling to left tchiness away.						
		Acetaminophen 650 mg . Resident stated no relief to pain.						
		Resident complained of n, requesting analgesics.						
	6/18/18, 8:29 a.m. stated no relief from	Pain scale 10. Resident 1 pain.						
		Acetaminophen 650 mg mplained of severe right leg						
		Acetaminophen 650 mg PRN ineffective. Pain scale 10 having any relief.						
	6/18/18, 8:03 p.m. /	Acetaminophen 650 mg given.						
		Acetaminophen 650 mg ve pain scale 5 still hurting						
	6/19/18, 12:03 a.m.	Very painful when assessing						

If continuation sheet Page 72 of 109

		AND HUMAN SERVICES			FORM	: 10/11/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245558	B. WING			C 10/2018
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	right foot which now ankle and top of foo two days. Rather t bed pan tonight. W 6/19/18, 5:09 a.m. to void tonight since in both feet. Now tr assist to raise up of chux. Resident will much pain to move (Acetaminophen) 6 6/19/18, 5:10 a.m. I resident needs to b mechanical lift. Not left breast. 6/19/18, 6:39 a.m. I assist out of bed wi swollen +2 and brui when transferred fr 6/19/18, 6:39 a.m. ineffective. Pain so rate pain severe. 6/19/18, 9:17 a.m. x-ray right foot relat pain following fall o 6/19/18, Called fam x-ray of right foot/an 6/20/18 at 11:00 a.r	v is bruised entirely around the of is swollen more than last than bear weight on it will use /ill get X-ray tomorrow. Has been using the bed pan e she is having so much pain otal lift of mechanical lift with 2 ff the bed to change soiled not turn, insists she's in too . Medicated with PRN Tylenol 50 mg for severe discomfort. Pain is so extreme that the re raised in bed using ed a bruise on under side of Has a whirlpool bath. Two th sit to stand lift. Right foot is ised Did have a lot of pain om bed to wheelchair. Acetaminophen 650 mg was cale 8. Resident continues to faxed MD questioning if needs ted to swelling, bruising and f 6/16/18. Fax received from MD that right foot/ankle. hily member and informed of nkle scheduled at hospital for	F 725			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL			U936-0391 E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245558	B. WING				C 10/2018
NAME OF I	PROVIDER OR SUPPLIER		ſ	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET WINDOM, MN 56101		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		DATE
			1		DEFICIENCE)		
F 725	Continued From pa	ae 73	F 7	25			
	for ankle pain.	0					
	6/20/18, 12:19 a.m.	Asleep at this time.					
	6/20/10 7.01 a m	Acetaminophen 650 mg					
	given. Resident co	mplained of severe right ankle					
	pain.						
		Acetaminophen 650 mg.					
	Administration was Resident stated hav	ineffective. Pain scale 8. ving no relief.					
		Resident left at 10:45 to get esident left in wheelchair.					
		Acetaminophen 650 mg given. ed of moderate pain in right analgesics.					
		Resdient arrived back at p.m. Right ankle was splinted.					
	and stated not so b	Discussed pain with residnet ad mostly hurts when I lie rs on it. Stated splint supports ortable.					
	6/20/18, 8:18 p.m. for pain scale of 4.	Acetaminophen 650 mg given					
	6/21/18, 3:10 a.m. given.	Acetaminophen 650 mg					
	6/21/18, 6:17 a.m. not effective. Pain	Acetaminophen 650 mg was scale 8.					
	6/21/18, 8:15 a.m. T ankle.	TO hospital for surgery right					

Facility ID: 00085

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		AND HUMAN SERVICES			P		APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245558	B. WING				C 10/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 74	F 7	25			
	she had right ankle in a wheelchair. Rig	Returned from hospital where repair about 6:30 p.m. She is ght foot is splinted and Rates pain at 8 of 10. Will ds arrive.					
	6/21/18, 8:30 p.m. (pain level of 8.	Given Ketorolac 10 mg for					
	identified nurse call for pain. Patient re- had an order for ice medication. At this	dated 6/17/18, at 1:00 a.m. ed requesting order for Tylenol cently sprained her left ankle, but no order for pain time Acetaminophen 325 mg hours PRN pain was ordered.					
	The fax identified R walking to the bathr ROM (range of mot putting pressure on want to stand on lef was faxed back to t p.m. with physician this, I assume all is noted as received b	e MD on 6/16/18, at 5:40 a.m. 16 was found on the floor room with 4 wheeled walker. ion) to left ankle painful when foot, no swelling. Does not it ankle. No bruising. The fax he facility on 6/18/18, at 12:20 comment, "I was called about now well. Yes? The fax was back at facility 6/18/18. No e physician regarding pain t ankle.					
		results dated 6/20/18, ype B distal fibular/lateral r the right ankle.					
	identified pain asso condition, non-phar ice and rest. The a	essment dated 6/18/18, ciated with a diagnosis or macological interventions of ssessment also identified the regime of PRN Tylenol 650					

Facility ID: 00085

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		AND HUMAN SERVICES			FORM	: 10/11/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245558	B. WING			C 10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET		
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	mg and ice PRN wa During interview wi (DON) on 8/9/18, at should have been in timely way than fax was done as far as effective, pain statu what was being dor with complaints of p changed since ther She stated R16 wat with walking prior to needed to be transf 2 assist. She stated called back on 6/18 back and told abour swelling and chang when they faxed on should have called her in for an x-ray th bruising on the 17th right which should h stated we have pain have used to make the Tylenol was obv control. During interview with 8/14/18, at 3:22 p.m been notified of the of the ankle. He sta the morning it happ see the fax from the 18th. At that time 1 and asked if everyting	as not working. ith the director of nursing t 10:24 a.m. she stated staff n touch with the Dr. in a more ing. She verified no follow up pain medication not being us, change in condition and ne to treat her. She stated pain something obviously e was swelling and bruising. s independent in her room o the falls but after the falls she ferred with mechanical lift and d the MD should have been 1/18, when we received the fax t the increased pain and e in condition. She stated n the 19th about an x-ray they and not faxed the Dr. to get hat day. She stated they saw n, first on the left then on the nave been addressed. She n meds in the e kit we could her more comfortable since viously not working for pain th the attending physician on n. he stated he should have increased pain and swelling ated he was notified of the fall ened. He stated he did not e 16 until Monday morning the he stated I responded back hing was ok. He stated I did ack from them until they	F 725			

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						<u>). 0938-039</u> TE SURVEY
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
			-			С
		245558	B. WING			8/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 725	Review of the polic 11/2016, indicates in consult with the rest a significant change mental or psychoso treatment significant change an existing commence a new f Hospice Coordinati The facility failed to for R41. R41's med certification/recertif a hospice start of c diagnosis of senile R41's significant ch identified R41 had and total dependent living. The MDS al receiving hospice s R41's care plan rev a terminal prognost dementia and was Interventions includ coping skills, conta needed, work with maximum comfort At the nurses station numerous papers w facility staff! R41 is hospice). The team social worker and of was identified. And	y Notification of Change dated the facility must immediately sidents physician when there is e in the residents physical, ocial status and a need to alter ntly - a need to discontinue or form of treatment or to form of treatment. on: occordinate hospice services dical director ication dated 6/7/18, identified are date of 3/18/18, with degeneration of the brain. hange MDS dated 3/23/18, a severely impaired cognition for all activities of daily so identified R41 was services. <i>v</i> ised 4/3/18, identified R41 had is related to end stage receiving hospice care. ded, assess resident and family act hospice staff for support as nursing staff to provide	F 7	25		

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		AND HUMAN SERVICES				FORM	: 10/11/2018 APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	0938-0391 E SURVEY PLETED
		245558	B. WING				C 10/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET /INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	Monday thru Friday Thurs/Fri. No patier paper nor are times care provided by the visit schedule on it. During observation hospice aide was p 7:43 a.m. R41 was being fed by a staff after giving R41 her During observation hospice aide was p During interview on assistant (NA)-D sta are going to do whe today they couldn't go do something els a bath and feed her her. We never kno times they come eit sometimes they do to come 3 days a w maybe only come the time. sometimes it' supposed to be her have come at like 4 During interview on stated you never kno come. Sometimes to leave because the else so they don't d supposed to. If they they just come anot	 Chaplain/SS (social service) in name is identified on this The hospice agency plan of e facility did not have any a on 8/8/18, at 7:05 a.m. resent giving R41 a bath. At sitting at the breakfast table member. Hospice aide left r bath. on 8/9/18, at 7:47 a.m. resent feeding R41. 8/8/18, at 8:13 a.m. nursing ated we don't know what they en they come. For instance feed her because they had to se. Sometimes they give her r, sometimes they just feed w. We don't know days or ther. Sometimes they tell us n't. I think they are supposed veek or something but they wo. We never know. They at 8, we never know. They in the afternoon before too. 8/8/18, at 8:30 a.m. NA-F now around here when they will they come and then they have hey have to go somewhere lo everything they are y can't make it they don't tell us 	F 7	25			

Facility ID: 00085

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	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION) <u>. 0938-039</u> FE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG		MPLETED
						С
		245558	B. WING			/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOODS	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 725	stated well there is aide comes every n Friday between 6 an chaplain and a soci of the week. The n was here yesterday comes a lot. If they they just come anot are stable so I'm no do let the nurse kno aides should be tolo During interview on practical nurse (LPI where the calendar know when they can stated the calendar During interview on aide (HA)-A stated of for R41. She stated have another patier aides and we all had depends on where them as to when the cares then I don't fe care then I feed her her hair. Normally I her. Yesterday I ha short someone calle up so I had to go. S staff really unless so just come in and go need to tell them so something is differe During interview or stated the hospice so	a calendar at the desk. The horning Monday through nd 8 a.m. they have a al worker that come later part urse comes on Tuesday, she 5. She has a volunteer that can't make it they don't tell us ther day. My hospice people of concerned about it. If they by they aren't coming then the d that too. 8/8/18 at 9:28 a.m. licensed N)-B stated she did not know for hospice was located to me. RN-B came onto unit and is under the clip board. 8/09/18, at 7:47 a.m. hospice we are here 5 days per week d I come at 5:30 because I at here. We have 5 different ve different schedules. It the clients are and who has ey come. If I do morning breakfast, play music, curl her bath is done so then I feed d to go because we were ed in so we had to split visits She stated I don't talk to the omething out of the ordinary. I to her room and help her. If I omething I will, like if ent or out of the ordinary. n 8/9/18, at 12:47 p.m. she should give us a schedule. m we don't know when their	F 7			

Facility ID: 00085

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(-)	E SURVEY PLETED
			A. DOILL			(C
		245558	B. WING				10/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	V	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPROP		DATE
			1		DEFICIENCY)		
F 725	Continued From pa	ae 79	E -	725			
1 720	communication for	-		25			
	communication for	continuity of care.					
	Edema Monitoring:						
		monitor edema (fluid					
		dema in feet/ankles. R7's ted 8/10/18, included					
	0	a, macular degeneration (an					
		uses vision loss), and					
	dementia.						
		rent physican orders dated					
		asix (a medication to reduce dy) 80 milligram (MG) daily for					
	edema.	dy) of minigram (MG) daily for					
		on 8/8/18, at 12:50 p.m., R7					
		we bilateral edema in her feet sident was sitting in a recliner					
	chair in her room w	ith her feet resting on the floor.					
		elcro closing shoes and grippy					
	,	there was visible indentation the grippy socks. The right					
		ddened appearance.					
	During observation	$an \frac{9}{0}/19$ at 9.46 a m					
		on 8/9/18, at 8:46 a.m. IA)-C transferred R7 into a					
		was wearing socks and shoes,					
		teral edema to ankles was					
	NA-C left the room.	remained on the floor when					
	During interview ar	0/0/10 at 10:04 a - NA O					
		8/8/18, at 10:04 a.m. NA-C					
	further stated there	were no specific interventions					
		ndicated R7 would elevate her					
	feet if she wanted to	υ.					
	During interview on	8/8/18, at 1:09 p.m.					

Facility ID: 00085

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/11/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245558	B. WING				C 1 0/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	registered nurse (R standing edema to confirmed there wa place for the edema During observation 2:22 p.m., R7 was s her feet on the grou lower extremities st RN-C further verifie redness present bu noted from R7. RN pitting edema (swel to cause an indenta the skin when depre ankle and foot and (indentation of 2 mi foot. RN-C stated support stockings ir R7 should have oth manage and monito was nothing in place During interview on director of nursing (extremity edema sh interventions in place SEE F684 FOR AD Activities of Daily Li R4 was not given a shaving. R4's care the resident require personal hygiene.	N)-B indicated R7 had long her lower extremities. RN-B s no formal monitoring in a. and interview on 8/9/18, at sitting in her recliner chair with and. RN-C assessed R7's ating they were cool and dry. d right lower extremity had a t no warmth or discomfort -C identified R7 had two plus ling that is significant enough tion of 3-4 millimeters deep in essed with a finger) in right one plus pitting edema llimeters) in left ankle and R7 had refused to wear n the past, however indicated er interventions in place to or the edema, confirming there e at this time. 8/10/18, at 2:48 p.m. the DON) confirmed R7's lower hould be monitored with be to control it. DITIONAL INFORMATION ving (ADL's): ssistance with nail care and plan reviewed 8/7/18 indicated d assistance of 1 staff with The care plan further identified of R4 was exhibiting	F 7	⁷ 25			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/11/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245558	B. WING				C 1 0/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	was noted to have I white hair on her ch During observation 7:16 a.m., R4 contri- chin hair. Nursing a R4's long dirty finge you'd let us trim you pleasant and coope and toileting, there shave chin hair or p During observation was observed in the an apple turnover w white chin hair. During observation 10:19 a.m., R4 com chin hair. NA-E sta mood" and it was a Though R4 was ple transfers, dressing offer of shaving, or a cares. NA-D furthe assistance with the confirmed R4 had le During interview on registered nurse (R fingernails and chin "goatee". RN-C inc will refuse cares, ho	on 8/6/18, at 1:56 p.m. R4 ong soiled fingernails and long nin. of morning cares on 8/8/18, at nued to have long nails and assistant (NA)-D looked at ernails and stated "oh I wish ar nails". Though R4 was erative with transfers, dressing was no attempt to trim nails,	F7	725			

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		AND HUMAN SERVICES				FORM	10/11/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED C
		245558	B. WING				10/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	On 8/10/18, at 3:02 (DON) stated her e trim nails and provi breakfast. The DO gotten R4 a new ra would expect staff t tasks when she wa R54 was not provid R54's care plan las self care performan hemiparesis and in dress, or groom. T R54 with several na Interventions includ personal hygiene a set up twice daily. R54's ADL care are 11/7/17 indicated en needed for all ADL' During interview on member- A stated s between R54's teet were being brushed	cleaned when R4 allows. P.m. director of nursing xpectation is for staff to shave, de oral cares prior to N further stated she had zor about one week prior and to reapproach or complete s cooperative if refused. He dassistance with oral care. t revised 7/4/18, identified a noc deficit related to left ability to independently bathe, he care plan further identified atural teeth broken off. led staff assistance with nd assist to brush teeth after as due to hemiplegia. 8/6/18, at 7:14 p.m. family she frequently notices food h and questioned if his teeth	F 7	225	DEFICIENCY)		
	room in a Broda ch not been brushed. dry toothbrush was cabinet above the s On 8/8/18, at 9:43 a sleeping in his bed.	air. He indicated his teeth had An oral care basin, including a s observed in the medicine					
L							

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	E SURVEY PLETED
		245558	B. WING				C 10/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 83	F7	725			
	On 8/8/18, at 1:19 p	o.m. toothbrush remained dry.					
	stated oral cares ar residents up in the	8/8/18, at 1:31 p.m. NA-C e completed when getting morning. NA-C then not brushed R54's teeth this e had "forgot".					
		p.m. director of nursing xpectation is for staff to per plan of care.					
	and eating. R48's of indicated the reside required extensive a	ed assistance with oral care care plan dated 7/7/18, ent had his own teeth and assistance of one staff with res to be performed BID (twice					
	member (FM)-G sta	on 8/6/18, at 4:17 p.m. family ated feeling R48's mouth had at times and wondered if staff					
	and NA-H were obs cares for R48. NA's recliner where he sl wheelchair (w/c) via propelled R48 into t then transferred R4 toilet. NA-D donner resident with washin hands and fingerna obtained a clean wa washed and dried F swishing his mouth	a.m. nursing assistants (NA)-D served providing morning s transferred R48 from the lept in the dining area, into his a a standing lift. NA-H then the tub room. NA-H and NA-D 8 via the standing lift onto the d gloves and assisted the ng his face then cleaned his ils thoroughly. NA-D then ashcloth and towel and R48's underarms. R48 was as if he had food or liquid in it. he needed to spit and brought					

Facility ID: 00085

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TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245558	B. WING _		C 08/10	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 725	spit. NA-D doffed h toothettes to utilize provide it. NA-D ar up and provided pe- licensed practical n room and complete after pericare was of completed the treat dressing R48 and t NA-H then brought breakfast; R48 was care. When interviewed of registered nurse (R related to oral care twice a day. RN-C always try to brush toothettes. Further review of R 7/24/18, indicated t assist of one staff v resident with a caln with adequate eatir indicated R48 holds needs reminders to On 8/6/18, at 5:50 p observed seated in dining room table ir supper meal; R48's At 6:00 p.m. nursin R48 and asked him was assisting anoth at that time. NA-G was on his plate; th	buth but the resident wouldn't her gloves and obtained for oral care but did not and NA-H then raised resident pricare; during that time urse (LPN)-A entered the tub and a treatment to R48's bottom completed. Once LPN-A tment, NA's then finished with ransferred him into his w/c. R48 out to the dining room for a not offered/provided oral on 8/9/18, at 10:59 a.m. N)-C stated the expectation was as the resident allowed further confirmed staff should R48's teeth rather than using 48's care plan, last revised he resident required extensive with eating, and to provide the n, quiet setting at meal times ng time. The care plan further s liquids/food in mouth and	F 72			

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		& MEDICAID SERVICES	0.00		<u>OMB NO</u>	APPROVE . 0938-039	
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED	
		245558	B. WING			C	
NAME OF	PROVIDER OR SUPPLIER	243330	D. Millar	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	/10/2018	
	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101	JDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 725	At 6:05 p.m., licensi approached R48 to were mixed in pudd NA-G, LPN-C event the medications in p required verbal pror swallow the medica in his mouth. The r a drink of his fluids the pudding that the R48 still had not ea assistance. The res fluids independently his food. At 6:28 p. assisted the resider resident had alread that time. R48 acce approximately 50% NA-K got up from th meal in the microwa front of R48. NA-K with eating his mea resident. At 6:55 p. with a bite of potato set it back down on observed to eat any he had been assisted When interviewed of stated R48 usually a not having any of it would check with th would eat a snack. On 8/9/18, at 9:49 a observed to prepare R48. LPN-A placeo	ed practical nurse (LPN)-C administer medications that ing. With assistance from tually was able to administer budding to the resident as he mpts and encouragement to tion as would swish it around esident was observed to take independently but other than e medications were mixed in, ten any of his meal nor offered sident continued to drink his v but would not attempt to eat m., NA-K sat next to R48 and at with eating his fruit, the y consumed all of his fluids at epted the offered food and ate of his fruit. At 6:40 p.m., he table and heated up R48's ave then set it on the table in did not offer to assist R48 I nor offer more fluids to the m., R48 picked up his fork es on it, raised it slightly, then the plate; R48 was not of his food other than the fruit	F 7				

Facility ID: 00085

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED		
		245558	B. WING			C / 10/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00	10/2010		
	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101				
(X4) ID PREFIX TAG			ID PREFIZ TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETIC DATE		
F 725	room; LPN-A did no eating. At 9:51 a.m going to try his breat respond. LPN-A the with eating. NA-D at 10:00 a.m. as went LPN-A was also add R48 at that time. LI medications in pudd a drink. R48 observed in his mouth. Wher LPN-A instructed Na more at that time as didn't want the reside R48 was observed his supplement into to administer medic were assisting othe LPN-A approached supplement from the assist the resident ware resident a drink of co accepted. LPN-A p the juice rather than mouth. LPN-A then continued to set-up At 10:26 a.m., R48 in his oatmeal; the r has food/fluid conter spit some of it out at with his fingers. At the dining room and they were going to P observed to take dr during the activity b himself. At 10:49 a replace NA-H on the approached R48 ar	ge 86 t offer to assist R48 with h., LPN-A asked R48 if he was kfast. The resident didn't en asked NA-D to assist R48 assisted R48 with eating until to assist another resident; ministering medications to PN-A administered R48's ding then offered the resident ved to swish the fluid around h NA-D returned to assist R48, A-D to not attempt to feed R48 is he wasn't swallowing and lent to choke. At 10:17 a.m., to place his glass containing his oatmeal; LPN-A continued ations and NA-D and NA-H r residents. At 10:21, a.m., R48, removed his glass of e oatmeal, and attempted to with eating. LPN-A offered the brange juice which he rompted R48 to try to swallow h swishing it around in his h washed his hands and and administer medications. was observed with his fingers resident continued to swish nts in his mouth. R48 would t times then wiped his mouth 10:34 a.m., the pastor entered d greeted the residents stating have hymn sing. R48 was inks of his Kemps supplement ut did not attempt to feed .m., NA-E (who had come to e unit at 10:00 a.m.), id cleaned the oatmeal off his d the resident if he was						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	i		PLETED C
		245558	B. WING				
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 705 SIXTH STREET		
GOOD S	AMARITAN SOCIETY	- WINDOM			WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	finished eating and NA-E also asked Re- juice and the reside When interviewed a that sometimes R44 independently and a assistance. When interviewed of confirmed R48 requires one staff with meals refuse to eat. RN-O resistive to assistant would stop and ther subsequent intervie RN-C stated the stat of people to feed and SEE F677 FOR MO Restorative Nursing R48 and R39 did no services per the plat R48's care plan, last the resident had a r intervention due to related to dementia freezing gait and ph plan interventions d perform active/pass walking program 2- Review of R48's Do dated May 2018-Au restorative nursing the following: May	the resident indicated he was. 48 if he wanted to finish his ent indicated that he did. at that time, NA-E confirmed 8 was able to eat sometimes required on 8/9/18, at 10:59 a.m. RN-C uired extensive assistance of a though sometimes he did C stated if the resident was nee would expect that staff in reapproach. On ew on 8/10/18, at 2:41 p.m. aff on Heritage Court had a lot not enough help. ORE INFORMATION g: ot receive restorative nursing an of care. st revised 7/24/18, indicated need for restorative limited physical mobility , Parkinsonism evidenced by nysical weakness. The care lirected nursing rehab staff to sive range of motion and a	F 7	725			

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		. 0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED	
		245558	B. WING _		08	C / 10/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 725	of 21 opportunities July 3018 - 2 times (7/2/18, 7/31/18). A opportunities (8/1/14) When interviewed of confirmed being put the floor if someone confirmed being put when interviewed of confirmed being put services to the Heri calling in. When as duties he was scher provided by another stated he didn't kno When interviewed of physical therapist (R the majority of the r therapy and NA-E a stated when a resid therapy a restorative PT-H confirmed it w assure the restorati completed by qualif When interviewed of director of nursing (services (HR) direct DON stated the res scheduled with the the monthly schedu try to have a least of scheduled daily Mor confirmed sometime staff to work on the	(6/8/18, 6/14/18, 6/19/18). out of 21 opportunities august 2018 - 1 out of 8 8). on 8/9/18, at 1:11 p.m. NA-E lled from restorative to work e called in. NA-E further lled from restorative that day. on 8/9/18, at 2:08 p.m. LPN-A lled from restorative nursing tage Court unit due to a staff sked if the restorative nursing duled to complete would be r staff in his absence LPN-A w. on 8/10/18, at 03:07 p.m. the PT)-H stated LPN-A completed estorative nursing rehab also had been trained. PT-H ent was discharged from e plan was then put into place. <i>vas</i> nursing's responsibility to ve plan was put into place and	F 72				

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		& MEDICAID SERVICES				OMB N	M APPROVE O. 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR			ATE SURVEY OMPLETED		
		245558	B. WING			C 			
NAME OF	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP C	ODE	DE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH WINDOM,					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	к (Е.	PROVIDER'S PLAN OF CO CACH CORRECTIVE ACTION DSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE		
F 725	confirmed not track services were gettin R48's restorative pl there were so many therapy. DON conf by the restorative si getting done. During interview wit she stated, I suppore week. I get arm any step. I am suppose band hand too. She it at all in August ye R39 took me to her spread sheet she h documented on the she received restor and 31. She stated on June 30 and sim- really bad. She stated on June 30 and sim- really bad. She stated to very good but I hav stated I am suppose Wednesday and Fr a.m. R39 was obse aide performing resi looked at surveyor, shoulders and smile R39 was asked if si laughed and pointe back of her door any will tell you. Staff ha 17 and 18th that resi that's how much I g walk 1-2 time a day	the R39 on 8/7/18, at 9:22 a.m. sed to get rehab 3 times a nd leg exercises and do the ed to have exercises on my e further stated I haven't had it. In July I had it 4 times.	F 7	25					

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245558	B. WING			C / 10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 725	stated I was able to can. I haven't done R39's care plan, las resident had a need due to limited physic weakness and old C accident) with right inability to independ Goal: resident will n mobility of transferr using handrail. Inter range of motion (RC with red T-band, 20 times per week, act left seated exercise times per week, act exercises with 0# w week, active ROM I times per week, pas reps as tolerated 3 plan updated 8/2/18 unable to ambulate using a total lift for t Review of R39's nu why resident was no per the care plan. A surveyor identified i changes in resident able to ambulate or restorative program order for skilled the be obtained to set u	was able to walk now she before but don't know if I still it for a lot of days. It revised 1/5/17, indicated the d for restorative intervention cal mobility related to CVA (cerebrovascular hemiparesis evidenced by lently transfer and ambulate. naintain current level of ing independently in bathroom reventions included active DM) upper extremity (U/E) left repetitions (reps) times 2, 3 ive ROM lower extremity (L/E) s with 3# weight 20 reps 3 ive ROM L/E right seated eights 10 reps 3 times per NuStep at level 5 10 min 3 ssive ROM to right arm 20 times per week. The care 8, also indicated R39 was or transfer independently	F 7	25		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/11/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245558	B. WING				C / 10/2018
NAME OF I	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	Review of R39's D dated June 2018-Ai restorative nursing the following: Wall 2018, 2 times (5//1 (6/4, 6/5, 6/11, 6/15 2018, 2 times (7/3 not applicable. Aug applicable rest x' d July 4 days (7/2, 7/5 August times 2 (8/7 When interviewed of physical therapy aid restorative is short getting done I think have aides When interviewed of confirmed being put the floor if someone confirmed being put she stated she gets and the NuStep. Si doing it if she refuse me. You have to try because she always from 9:15 to 9:30 it' M-Tu-Th if I don't ge someone retire at the always get done. When interviewed of confirmed being put services to the Heri calling in. When as duties he was sche	ocumentation Survey Reports ugust 2018 related to rehab completion indicated king 1-2 times per day: May 0, 5/29) June 2018, 7 times, 5, 6/18, 6/19 and 6/28). July , 7/9). 20 days were marked ust times 2 (8/1 and 8/2 non off). Restorative exercises: 5, 7/24, 7/31) 4 refusals. 7, 8/8). on 8/8/18, at 8:00 a.m. de (PTA)-A stated I know that so I don't know how much is nursing is doing it if they don't on 8/9/18, at 1:11 p.m. NA-E lled from restorative to work e called in. NA-E further lled from restorative that day. s upper and lower exercises he stated it depends on who is es. She has never refused for / to get her before bible study s goes to that if you get her s fine. She stated I see her et pulled to the floor. We had he end of June so it doesn't on 8/9/18, at 2:08 p.m. LPN-A lled from restorative nursing tage Court unit due to a staff sked if the restorative nursing duled to complete would be r staff in his absence LPN-A	F	725			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/11/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245558	B. WING	à			C / 10/2018
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 92	F	725	5		
	nursing assistant (N 2 assist 20-30 feet. couple weeks I thin as well as restorativ When interviewed of physical therapist (If the majority of the r therapy and NA-E a stated when a resid therapy a restorativ PT-H confirmed it w assure the restorati completed by qualif R39 had a program transferred to resto March she was on a her off in March she	on 8/10/18, at 03:07 p.m. the PT)-H stated LPN-A completed estorative nursing rehab also had been trained. PT-H lent was discharged from e plan was then put into place. was nursing's responsibility to ve plan was put into place and fied nursing staff. PT-H stated a while back and was rative. From January to a program. When they took e met standing and walking pendent in sit to stand. Did					
	director of nursing (services (HR) direct DON stated the rest scheduled with the the monthly schedut try to have a least of scheduled daily Mo confirmed sometim staff to work on the having concerns bro- restorative plans no confirmed not track services were gettir R48's restorative plane	on 8/10/18, at 3:25 p.m. the DON) stated the human tor was in charge of staffing. torative nursing staff is day sheet and included into ile. DON further stated they one restorative nursing staff nday through Friday. DON es they had to pull restorative floor. DON further stated not ought to her related to ot getting completed. DON ing if the restorative nursing ng completed. DON reviewed an and was surprised that ("holes" in the completion of					

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		AND HUMAN SERVICES				FORM	: 10/11/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245558	B. WING				C 10/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	therapy. DON conf by the restorative si getting done. The D not be documenting restorative sheets. available. She state wasn't walked in Ju with a change in co why she didn't get it retire end of June s get done July and A SEE F676 FOR AD RESIDENT/FAMILY OF STAFFING R48's quarterly MD R48 had severe cog required extensive a ADLs. When interv family member (FM a while for R48 to g staff had told her he prior to being incom feeling R48's mouth times and wondered R39's quarterly MD Brief Interview for M 15 indicating intact indicated R39 requi toileting. When inter 8/7/18, at 9:15 a.m. were short of help. working but a lot of wait. R39 further s	immed she had not been told taff that programming was not DON also stated staff should g not applicable on the It should be refused or not ed I don't know why she ally. She stated she just started andition this week. I don't know t in June. We had someone so that could be why it didn't August. DITIONAL INFORMATION Y CONCERNS WITH LACK S dated 6/29/18, identified gnitive impairment and assistance to complete his viewed on 8/6/18, at 4:07 p.m. I)-G stated sometimes it takes get help to get to the bathroom; e usually gets there on time tinent. FM-G further stated h had seemed quite dirty at d if staff brushed his teeth. S dated 6/15/18, identified a <i>M</i> ental Status (BIMS) score of cognition. The MDS further ired extensive assistance with	F 7	725			

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245558	B. WING				C 10/2018
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	00/	10/2010
COOD 6		WINDOM		70	5 SIXTH STREET		
GOODS	AMARITAN SOCIETY			W	INDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 94	F 72	'25			
	R16's Quarterly ME indicated R16 had a Status score (BIMS cognition. The MDS supervision with on for transfers and wa physical assistance hallway and toileting 8/6/18, at 6:44 p.m. bed pan at night be use those machine machines. R16 fur go over and then I w nightgown; they sai just have to put up R58's admission M BIMS score of 8 inc impairment. The M resident required ex transfer and toilet u 8/6/18, at 4:01 p.m. to an hour for assis further stated havin "It just happened la for over 20 minutes STAFF CONCERN When interviewed of medication aide (Th staffed Heritage Co NAs. TMA-A stated resident to staff rati the resident's sund stated she had wor	DS assessment dated 5/18/18, a Brief Interview for Mental b) of 15 indicating intact S also identified R16 needed e person physical assistance alking in room and limited e of one with walking in g. When interviewed on . R16 stated having to use the cause it takes two people to s (lifts) and I had to use the ther stated the bed pan would would end up with a wet d there is no other way you with it. DS dated 7/9/18, identified a dicating moderate cognitive IDS further indicated the stensive assistance with se. When interviewed on . R58 stated having to wait up tance with toileting. R58 g had accidents in my pants, st night. I was laying in poop s." S WITH LACK OF STAFFING on 8/6/18, at 2:34 p.m.trained MA)-A stated they usually ourt with 1 nurse or TMA and 2 d that was usually a good o though in the evening when own it can get really wild. TMA ked an evening shift last week she had 2 NA's on as it					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/11/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245558	B. WING				C 10/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 725	Continued From pa	ge 95	F7	725			
	stated she was sup a.m. this morning a leave. NA-H stated that stays and helps had to leave for her ran behind today. N could use more hel further stated feelin a staff person in the most residents gath sometimes that isn' to be in rooms to as then stated, "Yes, w R48 was not provid When interviewed of confirmed R48 requires one staff with meals refuse to eat. RN-O resistive to assistant would stop and the subsequent interviewed of from any other part staffing. LPN-A state building and also w LPN-A further state restorative today to nurse scheduled ca when working the d TMA or LPN schedule the residents their b	on 8/9/18, at 10:29 a.m. NA-H posed to be done at 10:00 nd is just getting ready to I they usually have a night aide is them get people up but she other job at 6:30 a.m. so they IA-H stated sometimes they p in Heritage Court. NA-H g that there should always be e main dining room area where her when out of their rooms; t possible when the staff need sist other residents. NA-H ve could use more help." ed assistance with eating. on 8/9/18, at 10:59 a.m. RN-C uired extensive assistance of s though sometimes he did C stated if the resident was not would expect that staff n reapproach. On ew on 8/10/18, at 2:41 p.m. aff on Heritage Court had a lot nd not enough help. on 8/9/18, at 2:08 p.m. LPN-A Court was really no different of the building as far as ted he floats all over the orks in restorative therapy. d he was pulled from work in Heritage Court as the illed in. LPN-A confirmed that ay shift on Heritage Court, the uled is responsible for serving oreakfast and further out his medication pass					

Facility ID: 00085

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	OMB NC	TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		MPLETED	
						С	
		245558	B. WING _		08/10/2		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (IP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE		
F 725		her confirmed nurses/TMAs	F 72	25			
	breakfast meal. W services he was to	not responsible for serving the hen asked if the restorative provide that day for residents npleted, LPN-A stated he didn't					
W sta Co hc ar wa re N/ tha sc sta ar fe ar of	states sometimes the Court but not always how the residents we and behaviors. NA was supposed to staresidents up but that NA-D further stated that refuse to stay us schedule those em stated today they diand it was really diffed as the other NA and was giving bath of the residents are	on 8/9/18, at 2:13 p.m. NA-D hey have enough in Heritage rs; a lot of it depended upon vere doing related to health -D stated the night staff NA cay until 7:30 a.m. to help get at doesn't always happen. It there are some night staff until 7:30 a.m. so they only ployees until 6 a.m. NA-D idn't have a night person stay ficult to get every one up and who worked until 10:00 a.m. ns. NA-D further stated many 2 person assist so she had to ce with those residents.					
	stated it depended could be very overv NA-I stated she usu that shift was the w 4:30 p.m. as they w staff during that tim day shift it's very bu resident's up in the staff will stay until 7 always. NA-I stated unit would definitely	on 8/10/18, at 10:36 a.m. NA-I upon the day but at times it vhelming in Heritage Court. ually worked evenings and felt orst, especially from 3:00 - vere many times down to 2 e. NA-I further stated on the usy when they are getting morning; usually a night shift 2:30 a.m. to help but not d having one more staff on the v help. NA-I also stated they a staff in the dining area as					

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	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
							C
		245558	B. WING			08/1	10/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			VINDOM, MN 56101		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B		BE	(X5) COMPLETION DATE			
F 725	time. When interviewed of director of nursing (services (HR) direct DON stated the rest scheduled with the the monthly schedu try to have a least of scheduled daily Mo confirmed sometim staff to work on the having concerns br restorative plans no confirmed not track services were gettin R48's restorative pl there were so many therapy. DON confi by the restorative si getting done.	ge 97 resent but it's a very short on 8/10/18, at 3:25 p.m. the (DON) stated the human tor was in charge of staffing. torative nursing staff is day sheet and included into ile. DON further stated they one restorative nursing staff nday through Friday. DON es they had to pull restorative floor. DON further stated not ought to her related to ot getting completed. DON ing if the restorative nursing ng completed. DON reviewed an and was surprised that y "holes" in the completion of irmed she had not been told taff that programming was not 8/10/18, at 3:34 p.m. the	F 7	25			
	human resources (HR) director stated they had determines the staffing on					
	administrator stated number of residents was disbursed was residents per statio Court- 2 day NAs a Evening the same a scheduled at night 4 day NAs, 1 nurse and Heritage Court	on 8/10/18, at 3:42 p.m. the d the acuity of staff is based on s in the building; where staff based on the acuity of the n. Ideal staffing: Heritage nd one nurse or TMA. and nights 1 NA (RN or LPN covers the building). Center - , 1 case manager for Center (400 and 500 wings), nd a nurse. Nights- 2 NAs.					

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PRINTED: 10/11/2018

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION). 0938-039 TE SURVEY MPLETED	
		245559	B. WING			С	
	PROVIDER OR SUPPLIER	245558		TREET ADDRESS, CITY, STATE, ZIP CODE	08/10/2018		
	AMARITAN SOCIETY	- WINDOM	705 SIXTH STREET WINDOM, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE	
F 725 F 755 SS=E	South: Days - 4 N/ manager. Evenings - 1 NA and 1 nurse The HR director co got pulled a lot to th cares vs completin	As, 1 nurse and case s - 4 NA's and 1 nurse. Nights nfirmed the restorative aide ne floor, to complete patient g restorative nursing tasks. rocedures/Pharmacist/Records	F 725 F 755			9/19/18	
	drugs and biologica them under an agre §483.70(g). The fa personnel to admin	Services ovide routine and emergency als to its residents, or obtain eement described in acility may permit unlicensed ister drugs if State law order the general supervision of					
	pharmaceutical ser that assure the acc dispensing, and ad	ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and t the needs of each resident.					
	•	Consultation. The facility tain the services of a licensed					
		ides consultation on all ision of pharmacy services in					
		blishes a system of records of tion of all controlled drugs in enable an accurate					

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		AND HUMAN SERVICES	1		FORM	10/11/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COM	E SURVEY IPLETED C
		245558	B. WING _			0 10/2018
NAME OF I	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 755	is maintained and p This REQUIREMEN by: Based on observat review, the facility f stored in 2 of 2 emo- expired, and availal situation. This had 78 residents residir needed these medi- situation. Findings include: On 8/9/18, at 2:18 p room was toured w (DON). A clear pla was housed in the n Inside, two unopen- antianxiety medicat (ml) were found to however both vials prior. Further, anot removed and inspe contained two unop antihistamine medi- were also found to A total four doses of identified with the n When interviewed i DON stated the dis responsible to mair they take ownership DON explained she	count of all controlled drugs beriodically reconciled. NT is not met as evidenced tion, interview and document ailed to ensure medications ergency drug kits were not ble for use in an emergent potential to affect any of the ng in the facility, who may have cations in an emergent o.m. the central medication ith the director of nursing stic tackle-style emergency kit refrigerator and inspected. ed vials of lorazepam (an tion) 2 milligrams (mg)/milliliter be available to resident use, had expired several months ther tackle-style kit was cted from the cabinet which bened vials of Benadryl (an cation) 50 mg / ml. These be expired. If expired medication(s) were nedication storage review. mmediately following, the pensing pharmacy was tain the emergency kits as to of the medications inside. was not sure when these kits for their expiration dates, and	F 75	 It is the current policy and proce GSS-Windom to assure all drug emergency kits are non-expired The expired medications were re and replaced on Aug. 9, 2018 by Drug. All other medication expir dates were also checked at this found to be current. On Sept. 5, 2018, the consulting pharmacist was re-educated on emergency kits and his role in c the dates of the drugs. All licens nursing staff will be re-educated Sept.11-12, 2018 for their role in medications in the emergency k current. The local pharmacist w re-educated on Aug. 14, 2018 re his responsibility to ensure the medications are current. An audit of medication expiration the emergency kits will be condu- the Director of Nursing Services designee, 1x weekly for 13 weel results will be reviewed by the C committee with appropriate follo initiated to ensure solutions are 	s in the emoved Lewis ation time and the necking sed ensuring ts are as garding n dates in icted by or s. Audit API w-up	

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		AND HUMAN SERVICES		FC	TED: 10/11/2018 DRM APPROVED
STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NO. 0938-0391) DATE SURVEY COMPLETED
		245558	B. WING		C 08/10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
F 755	Continued From pa	ge 100	F 755	5	
F 812 SS=F	provided afterwards refrigerator emerges since 4/14/17. No provided to demons the Benadryl had be A provided Procedu policy dated Septer emergency kits wer and, "The pharmac monitoring expiration Food Procurement, CFR(s): 483.60(i)(1) §483.60(i) Food sat The facility must - §483.60(i)(1) - Proce approved or consident state or local autho (i) This may include from local producer and local laws or ref (ii) This provision def facilities from using gardens, subject to safe growing and foc (iii) This provision def from consuming for §483.60(i)(2) - Stor serve food in accor standards for food s This REQUIREMEN	ure for Emergency Drug Boxes nber 2012, identified the re provided by the pharmacy ist is responsible for on dates." Store/Prepare/Serve-Sanitary)(2) fety requirements. cure food from sources ered satisfactory by federal, rities. e food items obtained directly rs, subject to applicable State egulations. oes not prohibit or prevent produce grown in facility compliance with applicable pod-handling practices. loes not procured by the facility. e, prepare, distribute and dance with professional	F 812	It is the current policy and procedure	9/19/18 Df

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	0938-039
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	NG		IPLETED
		245558	B. WING			C
	PROVIDER OR SUPPLIER	240000	D. WING	STREET ADDRESS, CITY, STATE, ZIP COL		10/2018
	noviden on our cient			705 SIXTH STREET		
GOOD S	AMARITAN SOCIETY	- WINDOM		WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 812	Continued From pa	ae 101	۲ F 8	12		
	were heated and see prevent potential fo facility failed to ensure was maintained in a and failed to ensure measures were imp cross contamination non-original contain potential to affect a facility at the time o Findings include: On 8/7/18, at 11:20 was observed. Coo on the steam table population including mashed potatoes, s gravy. In addition, o pureed pork chops pork chops and tac stated these items the oven and place moments prior. CK- temperatures on a the taco meat and p temperatures for se prepared items had demonstrate they h serving temperatures	a.m. the lunch meal service ok (CK)-A had several items to be served to the resident g taco meat, pork chops, sage dressing, kernel corn, tan CK-A had pureed carrots, and mechanical soft texture o meat to be served. CK-A had just been removed from d in the steam table a few		 GSS-Windom to serve meals accordance with professional for food service safety and to clean and sanitary kitchen environment of the can opener and mixer were on Aug. 6, 2018. The plastice and scoop were washed and the powdered sugar disposed of the 2018. The thermometer was and re-located to its own cont Aug. 7, 2018. The food temps were re-taken on Aug. 7, 2018 to be compliant, as the cook here taken the temperatures in Cell of Fahrenheit. The cook was re-educated by the dietary sugh how to store, sanitize, and reat thermometer. All other kitchen equipment is this deficient practice and was and followed up on as approp Dietary Supervisor for cleanlin 6, 2018. The kitchen cleaning will be audited and updated as by the Dietician, and the Dieta Supervisor on Sept. 12, 2018. All dietary staff will be re-educated and their of the cleaning practices and the process and	standards provide a vironment. ere cleaned container the on Aug. 6, sanitized ainer on s on Aug. 7 8 and found had originally sius instead immediately pervisor on ad the at risk for s audited riate by the ness on Aug. g schedules s necessary ry	
	was going to check temperature upon r the kitchen. The su temperature check CK-A removed a ba	een checked and stated he the other food items eturn from being away from irveyor requested a on the prepared items, and ayonet-style thermometer from on the counter which		cleaning schedules which incl items, on Sept. 12, 2018 by th and Dietary Supervisor. All co re-educated on thermometer storage, and sanitizing on Sep by the Dietician and Dietary S	e Dietician ooks will be reading, ot. 12, 2018	

Facility ID: 00085

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPLE (CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		045550				С		
		245558	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	08/10/2018		
NAME OF	PROVIDER OR SUPPLIER				SIXTH STREET			
GOOD S	AMARITAN SOCIETY	- WINDOM			NDOM, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE	
F 812	contained another t various pens and p the thermometer be food items to be se observed the therm aloud the following for the various food Taco meat - 91 deg Pork chop - 94 F, a Sage dressing - 91 CK-A then turned to aloud, "What do yo surveyor asked CK would be to implem low, however, CK-A would be upset if th did not want to over stated he would wa food in the steam ta temperature. Appro CK-A checked the s no temperature cha the oven. CK-A did other food items ba they were hot enou CK-A checked all th following temperatu- steam table: Taco meat - 91 F, Pork chop - 94 F, Sage dressing - 91 Corn - 97 F, Gravy - 81 F and,	hermometer, a scissors and encils. CK-A did not sanitize efore placing it in the prepared rved. CK-A and the surveyor iometer, and CK-A stated temperatures being identified items: rees Fahrenheit (F), nd, F. o the surveyor and stated u want me to do?" The -A what his normal process ient if food temperatures were A responded the residents' ie meal was too late and he rcook the food items. He it five or 10 minutes with the able and then recheck the oximately 10 minutes later, sage dressing and there was ange, so he placed it back in I not check or place any of the ick into the oven to ensure gh to serve. At 11:45 a.m. he food items and identified the irres while they were in the F,	F 8		An audit by the QAPI Director or will occur of kitchen equipment cleanliness and appropriate food temperatures at serving time, 3x, 4 weeks and then weekly x8 wee results will be reviewed by the Q/ committee with appropriate follow initiated to ensure solutions are s	/week for ks. Audit API v-up		

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		AND HUMAN SERVICES				FORM	: 10/11/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245558	B. WING	ì			C 10/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- WINDOM			705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	After obtaining the function of the serve the food from Dietary manager (D findings, and stated re-heated to ensure DM-A acknowledge become upset with know its bad, but w The residents will b stated the thermom cup with pencils and been sanitized befor temperatures. On 8/9/18, at 10:30 was conducted with RD-A expressed for when hot enough, a to understand and H temperatures to ser expressed if staff h- thermometer function thermometer to che The facility's Food 7/2018, identified th sanitized when rem before being inserter policy further indica solution should be u food debris. The facility's Food 7/2018, identified th	temperatures, CK-A m table and brought it to the lespite the low temperatures K-A then began to plate and the steam table. DM)-A was alerted to these d the food should have been e a safe serving temperature. ed the residents' would likely having to wait and added, "I hat else can I choose to do? the upset." Further, DM-A neter should not be stored in a d scissors, and should have bre used to check food a.m. a telephone interview n registered dietician (RD)-A. od should only be served and she expected facility staff know the right food rve at. Further, RD-A	F	812			

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		AND HUMAN SERVICES				FORM	10/11/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245558	B. WING				C 10/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM			05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 812	listed, "cold food <4 food >135 degrees directed food should cooled to ensure pri before each meal si which included the - Before meal serving the "cook-to" and "si Time/temperature O items and records of Record," - If temperatures are guidelines, food and acceptable temperat - TCS hot foods sho F or higher. EQUIPMENT / STO On 8/6/18, at 2:15 p completed with diet single, automatic ca which had visible re substance running of backing of the devid and bowl was cover was removed and t found areas of white smeared substance the extended arm p is located (directly a single plastic contai on the counter whice Inside the container	A1 degrees Fahrenheit, hot Fahrenheit." The policy d be cooked, reheated or oper holding temperatures ervice, and listed a procedure following steps: ce, the cook/designee takes serve" temperatures of "all Control for Safety [TCS] menu on the Food Temperature re not within recommended d/or fluids are reheated to atures before service, and, ould be served at 135 degrees	F 8	312			

Facility ID: 00085

If continuation sheet Page 105 of 109

		AND HUMAN SERVICES		FOF	ED: 10/11/2018 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED
		245558	B. WING		C)8/10/2018
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINDOM		05 SIXTH STREET VINDOM, MN 56101	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From pa powdered sugar.	ge 105	F 812		
	acknowledged the	at the same time, DM-A observations of the soiled ed the scoop should not be ner.			
	listing identified sev completed. A bulle complete " any ot done," and "kitchen leave!" In addition, sheets were review	d Day and Evening Cook's veral cleaning tasks to be tpoint directed staff to her cleaning that needs to be should be spotless when you provided weekly cleaning ed and lacked any directed ors, windows, screens nor fans			
F 921 SS=C	requested, but not Safe/Functional/Sa	uipment cleaning was provided. nitary/Comfortable Environ	F 921		9/19/18
	The facility must pro- sanitary, and comformer residents, staff and	nvironmental Conditions ovide a safe, functional, ortable environment for the public. NT is not met as evidenced			
	Based on observative review, the facility for sanitary environmed debris in 1 of 1 main prepare and server failed to ensure fluit machines were kep in 1 of 3 kitchenetter.	tion, interview and document ailed to provide a clean, nt which was free of dust and n production kitchens used to food. In addition, the facility d and/or ice dispensing of in a clean, sanitary manner es used. These findings had ffect all 78 residents currently ty.		It is the current policy and procedure of GSS-Windom to provide a clean and sanitary environment. The window, fan, and kitchenette equipment were cleaned on Aug. 8, 201 All the kitchen windows and fans and kitchenette equipment is at risk for this deficient practice and was audited and	

Facility ID: 00085

If continuation sheet Page 106 of 109

CENTE STATEMENT AND PLAN OF		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245558 - WINDOM		NG _ S ⁻	FO OMB N E CONSTRUCTION (X3) ((X3) ((X3) ((X3) ((X3) ((X3	RM A <u>NO. (</u> DATE COMP	10/11/2018 PPROVED 0938-0391 SURVEY LETED 0/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		VINDOM, MN 56101 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 921	completed. A crani along the south sid dietary manager's of screen covering the window. The scree of thick clumping di splatters of white a droppings. In addit was attached to the The fan blades' eac colored dust attach blades. The fan wa During subsequent 11:20 a.m. the wind to have the same a clumping dust. The screen, nor the fan observed on 8/6/18 On 8/8/18, at 10:00 (DM)-C observed a the window screen kitchen. DM-C state maintenance when and there was no fo assigned to it. DM- several weeks sinc Further, DM-C state responsible to clea A provided, undated listing identified sev	b.m. the initial kitchen tour was k-style window was observed e of the kitchen next to the office with a visible metallic e entire, inner aspect of the en had numerous visible areas ust, with cobwebs and several nd black colored bird tion, a single oscillating fan e wall in the soiled dishes area. ch had visible, clumping black ed to the surfaces of the s not turned on at this time. observation on 8/7/18, at dow screen and fan continued uppearance with visible ere was no visible evidence the had been cleaned since first	F 9	21	followed up on as appropriate by the Dietary Supervisor for cleanliness on At 8, 2018. The kitchen cleaning schedule and the maintenance cleaning schedule will be audited and updated as necessa by the Maintenance Director, the Dietician, and the Dietary Supervisor or Sept. 11 and 12, 2018. All dietary staff will be re-educated on cleaning practices and their current cleaning schedules which include the kitchenette equipment, on Sept. 12, 207 by the Dietician and Dietary Supervisor. All maintenance staff will be re-educate by the Maintenance Director on Sept. 1 2018 on cleaning of windows and fans if the kitchen and the ice maker in the kitchenette, as well as their current cleaning schedules, which include these items. An audit by the QAPI Director or design will occur of the cleanliness of kitchenet equipment and the kitchen windows and fans, 3x/week for 4 weeks and then weekly x8 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	es es iry 18 d 1, in e ee ette d	

	TOF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	COMPLETED	
		245558	B. WING		08	C / 10/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2010
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 921	done," and "kitchen leave!" In addition, sheets were review tasks to ensure floo were included. No policies on kitch maintenance were p KITCHENETTE: On 8/6/18, at 6:00 p was observed. A si counter which had of dispensed. The sur behind the spigot w sticky substances re down to the drip tra- automatic ice dispe counter. The mach flaky, dried sedimer surface of the device inside the attached spigot automatic co white colored sedim along the seam for tray attached to the On 8/7/18, at 8:00 a observed again. Th continued to be soil 8/6/18, with no evid On 8/8/18, at 10:00 with dietary manage acknowledged the f	her cleaning that needs to be should be spotless when you provided weekly cleaning ed and lacked any directed rs, windows, screens nor fans en cleanliness or provided.	F 9	21		

If continuation sheet Page 108 of 109

		AND HUMAN SERVICES			FORM	D: 10/11/2018 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245558	B. WING		80	C / 10/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 921	The undated Thurs directed staff to, "C Further, Friday Clea "Wipe down ice ma A provided Day and directed the evenin	eek listing of cleaning duties. day Cleaning Duties listing lean up juice machine." aning Duties directed staff to,	F 921			

Facility ID: 00085

		AND HUMAN SERVICES	1	Ŧs	558027 0		APPROVED
F	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			01 - MAIN BUILDING 01	CON	IPLETED
		245558	B. WING			08/	08/2018
NAME OF F	PROVIDER OR SUPPLIER			0	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		0	05 SIXTH STREET VINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	КC	000			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio Good Samaritan So to be in compliance participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA)	Survey was conducted by the ent of Public Safety, State on. At the time of this survey, ociety Windom was found not with the requirements for icare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety ter 19 Existing Health Care					
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY			EPOC		
	Health Care Fire Ins State Fire Marshal I 445 Minnesota Stre St. Paul, MN 55101	Division et, Suite 145				J	
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE
Electron	ically Signed						09/07/2018

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.

PRINTED: 09/10/2018

		E & MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /	IPLE CONSTRUCTION Ig 01 - Main Building 01		TE SURVEY MPLETED
		245558	B. WING		08	/08/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
K 000	Continued From pa	age 1	K 00	00		
	By email to:					
	Marian.Whitney@s	state.mn.us itney@state.mn.us> and				
	Angela.Kappenma					
		openman@state.mn.us>				
		RRECTION FOR EACH TINCLUDE ALL OF THE				
	1. A description of to correct the defic	what has been, or will be, done iency.				
	2. The actual, or pr	oposed, completion date.				
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.				
	building with partial constructed at five building was constr additions in 1962, 1 buildings were deter	bociety Windom is a one-story basement, and was different times. The original ructed in 1959, with building 1972, 1994 and 2000. All ermined to be of Type II(111) facility is fully sprinklered.				
	detection in the cor open to the corrido automatic fire depa	fire alarm system with smoke ridors, including all spaces rs, which are monitored for rtment notification. The facility 8 beds and had a census of 71 y.				
	NOT MET as evide	-				
K 211	Means of Egress -	General	K 21	1		9/8/18

Facility ID: 00085

If continuation sheet Page 2 of 3

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
		245558	B. WING		08/0	8/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH STREET WINDOM, MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	IX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETIC DATE
	exit locations, and a with Chapter 7, and continuously mainta full use in case of e 18/19.2.2 through 1 18.2.1, 19.2.1, 7.1. ⁻ This REQUIREMEN by: Based on observat failed to be in accord states, all means of maintained free of a case of emergency affect 71 of the 71 n Means of Egress - Aisles, passageway exit locations, and a with Chapter 7, and continuously mainta full use in case of e 18/19.2.2 through 1 18.2.1, 19.2.1, 7.1. ⁻ FINDINGS INCLUE On facility tour betwo on 08/08/2018, obs pedestrian gate from	General /s, corridors, exit discharges, accesses are in accordance I the means of egress is ained free of all obstructions to mergency, unless modified by 18/19.2.11. 10.1 NT is not met as evidenced tion and interview, the Facility rdance with Chapter 7, which f egress is to be continuously all obstructions to full use in . This deficient practice could residents. General /s, corridors, exit discharges, accesses are in accordance I the means of egress is ained free of all obstructions to mergency, unless modified by 8/19.2.11. 10.1	K 211	K-211 Corrected Date: Aug. 8, 2018 The gate was not able to be used was locked. The gate was unlock immediately on Aug. 8, 2018 and unlocked. Nursing Staff were re- by the Maintenance Director on A 2018 to not lock the gate. The log gate will be changed (made inope by Sept. 19, 2018, so it will no lon risk. There are no other gates loc outside the building. This issue w reported to the Safety Committee follow-up.	ked remains educated ug. 8, ck on the erable) ger be at cated vas	

Facility ID: 00085

If continuation sheet Page 3 of 3

PRINTED: 09/10/2018



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 29, 2018

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

Re: State Nursing Home Licensing Orders - Project Numbers S5558026, H5338024

Dear Administrator:

The above facility was surveyed on August 6, 2018 through August 10, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Good Samaritan Society - Windom August 29, 2018 Page 2

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 contact Holly Kranz, Unit Supervisor at (507) 344-2742 or at holly.kranz@state.mn.us.

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Licensing and Certification Program Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

cc: Licensing and Certification File

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00085	B. WING		08/1	; 0/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET , MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	You may request a that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	o participate in the electronic insure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electron	ically Signed					09/07/18

STATE FORM

If continuation sheet 1 of 102

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			C
		00085	B. WING		08/10/2018	
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading le date your orders will be lectronically submitting to the nent of Health.				
	surveyors of this De above provider and orders are issued. electronic plan of c	, 8th, 9th, and 10th, 2018, epartment's staff visited the I the following correction Please indicate in your orrection that you have lers, and identify the date wher ted.	1			
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled " II statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, NN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
					С	
		00085	B. WING	B. WING		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		TH STREET M, MN 56101			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
		QUIREMENT TO SUBMIT A				
		CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 265	MN Bule 4658 0084	5 Notification of Chg in	2 265			9/19/18
2 200	Resident Health Sta		2 200			5/15/10
		ist develop and implement				
		aff decisions to consult				
		an assistants, and nurse known, notify the resident's				
		e or an interested family				
		ent's acute illness, serious				
		At a minimum, the director of				
		nd the medical director or an must be involved in the				
		se policies. The policies must	t			
	have criteria which appropriate notifica	address at least the				
		involving the resident which				
	physician intervention	I has the potential for requiring on;				
		change in the resident's				
		r psychosocial status, for				
		ation in health, mental, or in either life-threatening				
	conditions or clinica					
		ter treatment significantly, for				
		discontinue an existing form				
	begin a new form o	adverse consequences, or to f treatment;				
		o transfer or discharge the				
	resident from the nu	ursing home; or				

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00085	B. WING		08/1	; 0/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET , MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	E. expected an	d unexpected resident deaths.				
	by:	ent is not met as evidenced				
	review the facility fachange of condition 3 resident (R16) an	on, interview, and document ailed to notify the physician of a a after a fall with injury for 1 of d bruising which increased in or 1 of 1 resident (R24)		Corrected		
	Findings include:					
	R16 was admitted t	ecord face sheet identified the facility with diagnosis ed convulsions, muscle story of falling.				
	assessment dated Brief Interview for N 15 indicating intact identified R16 need person physical ass walking in room and of one with walking	himum Data Set (MDS) 5/18/18, indicated R16 had a Mental Status score (BIMS) of cognition. The MDS also led supervision with one sistance for transfers and d limited physical assistance in hallway and toileting. R16 aving no pain and no falls hent 2/23/18.				
Ainpocoto D	identified R16 had a R/T (related to) urin weakness evidence The goal was identi usual activities with Interventions includ PRN (as needed) ti	plan, last revised 6/18/18, an actual fall with minor injury pary tract infection (UTI) with ed by fell times 2 on 6/16/18. ified as resident will resume out further incident. led monitor/document/report mes 72 hours to health care ns/symptoms) pain, bruises				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
		00085	B. WING			C	
						08/10/2018	
	PROVIDER OR SUPPLIER	705 SIXT	DRESS, CITY, ST H STREET	IATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 265	Continued From pa	age 4	2 265				
	mobility, positioning balance and lower plan problem dated resident had acute ankle fracture with Review of incident a.m. identified staff knocking since resi 5:30 a.m. as per us the floor next to the Walker next to her. what happened. Le more swollen than bear any weight aft	nificant changes in gait, g device, standing/sitting extremity joint function. A care I 6/20/18, identified the pain/discomfort R/T right surgical repair. report dated 6/16/18, at 5:40 went into R16's room after ident did not put on call light at sual. R16 was found sitting on bathroom door frame. R16 stated she didn't know eft foot tender to touch, no other ankle. R16 not able to er assessing ankle, no by ankle back and forth, up					
	a.m. identified resid bathroom as she have wheeled R16 into the grab bar to stand u out of the room so suddenly let self sli witnessed. The rep cause of the fall ma foot was hurting sir earlier. R16 was as and 2 staff onto be as 2. Review of nursing r 6/16/18, 7:36 a.m. and sent to WAH (I	report dated 6/16/18, at 7:25 dent was taken to the ad her call light on. Staff he bathroom. R16 used the p. Staff moved the wheelchair to help resident. Resident p to the floor. The fall was bort also identified the root ay have been that R16's left nee she had fallen 2 hours ssisted with the mechanical lift d. Pain rating was identified notes are as follows: Urine specimen was obtained ocal hospital) for U/A (urine order. Urine is cloudy and					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
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2 265	Continued From pa	ige 5	2 265				
		Ice pack for swelling to left s as needed apply to left ankle g pain in left ankle.	9				
	hours. Alert but co since 10 p.m. last r a.m. as was checked were no screams c that there was no o night. No tears, fla reddened areas of painful after admini mg. Called primary urine is very foul ar in last two hours. U to lift her off the floo bathroom, hung on remove the wheelc	Resident fell twice within 2 nfused, states "I laid there night". She was in bed at 3:30 ed by this writer (staff). There oming from room as evidence bvious way she sat there all t affect, and skin had no pressure. Left ankle was still stration of PRN Tylenol 650 y doctor since she is confused, d incontinent of urine times 2 Jsed mechanical lift both times or. Resident stood up in to grab bars until writer could hair to assist her to pivot onto y, she went down slowly on her					
	phoned Dr. to informankle, no swelling a	After second fall in 2 hours, m she had fallen twice, hurt lef after 2 hours of initial fall and or. New orders received A to be done).	t				
	ankle and was brou	Applied ice pack to left outer ught to dining room for complaints of pain while te's at breakfast.					
	ankle every 4 hours ankle for swelling P	Ice pack for swelling to left s as needed. Apply to left PRN (as needed) effective not swollen but still					
	C/1C/10 11.00 a m	Received phone call from Dr					

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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2 265	Continued From pa	age 6	2 265				
	given one dose it w allergy, call MD info medication. He sta shouldn't be a prob	red Cipro, after resident was vas noted that she had an ormed him she had allergy to ated no concern and it lem, just watch her. MD then bid 100 mg twice daily for 7					
	weight on left ankle stand times two as Left ankle not swoll pack to affected are (electronic long terr	Due to not able to bear full after her fall, now using sit to sist to use bedside commode. len but is painful. Applied ice ea. Call placed to eLTC m care Dr. available via video) licate with PRN Tylenol.					
	mg give by mouth e pain. Acetaminoph per day. Contact p	Acetaminophen tablet 650 every 4 hours as needed for nen not to exceed 3,000 mg rovider/practioner if fever is rt in left ankle, rates 5 out of					
	ankle, every 4 hour	. Ice pack for swelling to left is as needed. Has ice pack to en but is very tender to touch.					
	pain in left ankle. C falls 6/16/18. Spok	Phoned eLTC in regards to Change of condition after her with (eLTC staff) about no Will receive orders via fax.					
	6/17/18, 1:23 a.m. and effective. Follo	Acetaminophen was given wup pain score 5.					
	6/17/18, 2:32 a.m. ankle.	Ice pack for swelling to left					
		Resident was sitting up on er (staff) went by. Asked					

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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2 265	Continued From pa	age 7	2 265				
	said feels better that	pain, stated it's better now, an yesterday. Able to bear full left foot. Transferred with sit m.					
	6/17/18, Acetamino general aches.	ophen 650 mg given for					
		Ice pack for swelling to left ain in left ankle as 8 out of 10.					
	6/17/18, 6;05 a.m. it feels the same.	Ice pack for swelling. Stated					
		Acetaminophen 650 mg ineffective pain scale was a 5					
	can stand on my le sit to stand lift put r	Resident stated I don't think I ft leg. When transferred with nost of weight on that leg with r complaints. Denied pain re.					
		Resident stated right ankle le bruise on inner right ankle. nitor.					
		Acetaminophen 650 mg given le to bear weight on both legs inful."					
	6/18/18, 2:12 a.m. ankles.	Ice pack applied to both					
	and can't stand on stand lift for transfe that leg with no fac	Stated "I hurt my right ankle my leg". When placed in sit to er placed most of weight on ial grimace or complaints. Has inner right foot. Stated its a					

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NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
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2 265	Continued From pa	age 8	2 265				
	little sore scant swe	elling bilateral feet.					
	6/18/18, 2:48 a.m. ankle. Took the pa	Ice pack for swelling to left tchiness away.					
		Acetaminophen 650 mg 9. Resident stated no relief to pain.					
		Resident complained of n, requesting analgesics.					
	6/18/18, 8:29 a.m. stated no relief from	Pain scale 10. Resident n pain.					
		Acetaminophen 650 mg omplained of severe right leg					
		Acetaminophen 650 mg PRN ineffective. Pain scale 10 having any relief.					
	6/18/18, 8:03 p.m.	Acetaminophen 650 mg given					
		. Acetaminophen 650 mg e pain scale 5 still hurting					
	right foot which nov ankle and top of for two days. Rather	. Very painful when assessing w is bruised entirely around the ot is swollen more than last than bear weight on it will use /ill get X-ray tomorrow.					
	to void tonight since in both feet. Now t assist to raise up o	Has been using the bed pan e she is having so much pain otal lift of mechanical lift with 2 ff the bed to change soiled I not turn, insists she's in too	2				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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2 265	Continued From pa	age 9	2 265				
		 Medicated with PRN Tylenol 50 mg for severe discomfort. 					
	resident needs to b	Pain is so extreme that the be raised in bed using ted a bruise on under side of					
	assist out of bed w swollen +2 and bru	Has a whirlpool bath. Two ith sit to stand lift. Right foot is ised Did have a lot of pain rom bed to wheelchair.					
		Acetaminophen 650 mg was cale 8. Resident continues to					
		faxed MD questioning if needs ted to swelling, bruising and of 6/16/18.	5				
	6/19/18, 2:41 p. m. may obtain x-ray o	Fax received from MD that fright foot/ankle.					
		nily member and informed of nkle scheduled at hospital for m.					
	6/19/18, 8:10 p.m. for ankle pain.	Acetaminophen 650 mg given	1				
	6/20/18, 12:19 a.m	. Asleep at this time.					
		Acetaminophen 650 mg omplained of severe right ankle	,				
		Acetaminophen 650 mg. ineffective. Pain scale 8. ving no relief.					

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- WINDOM	TH STREET I, MN 56101			
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2 265	Continued From pa	age 10	2 265			
		. Resident left at 10:45 to get Resident left in wheelchair.				
		Acetaminophen 650 mg given ed of moderate pain in right analgesics.				
		Resdient arrived back at p.m. Right ankle was splinted 5.				
	and stated not so b	Discussed pain with residnet bad mostly hurts when I lie rs on it. Stated splint supports fortable.				
	6/20/18, 8:18 p.m. for pain scale of 4.	Acetaminophen 650 mg giver				
	6/21/18, 3:10 a.m. given.	Acetaminophen 650 mg				
	6/21/18, 6:17 a.m. not effective. Pain	Acetaminophen 650 mg was scale 8.				
	6/21/18, 8:15 a.m. ankle.	TO hospital for surgery right				
	she had right ankle in a wheelchair. Ri	Returned from hospital where e repair about 6:30 p.m. She is ight foot is splinted and Rates pain at 8 of 10. Will ods arrive.				
	6/21/18, 8:30 p.m. pain level of 8.	Given Ketorolac 10 mg for				
		C dated 6/17/18, at 1:00 a.m. led requesting order for Tylend	J			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE. ZIP CODE	08/10/201		
		705 SIXT	H STREET				
GOOD S	AMARITAN SOCIETY	- WINDOM	, MN 56101				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
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2 265	Continued From pa	age 11	2 265				
		-					
		cently sprained her left ankle, but no order for pain					
		time Acetaminophen 325 mg					
		hours PRN pain was ordered.					
	A fax was sent to the	ne MD on 6/16/18, at 5:40 a.m.					
		16 was found on the floor					
	walking to the bath	room with 4 wheeled walker.					
	ROM (range of mo	tion) to left ankle painful when					
	putting pressure on	foot, no swelling. Does not					
	want to stand on le	ft ankle. No bruising. The fax					
	was faxed back to	the facility on 6/18/18, at 12:20					
		comment, "I was called about					
		now well. Yes? The fax was					
		back at facility 6/18/18. No					
		ne physician regarding pain					
	and swelling of righ	it ankle.					
	Review of the x-ray	results dated 6/20/18,					
		type B distal fibular/lateral					
	malleolar fracture c						
		essment dated 6/18/18,					
		ciated with a diagnosis or					
		macological interventions of					
		ssessment also identified the					
		regime of PRN Tylenol 650					
	mg and ice PRN wa	as not working.					
	During interview wi	th the director of nursing					
		t 10:24 a.m. she stated staff					
		n touch with the Dr. in a more					
		ing. She verified no follow up					
		pain medication not being					
		is, change in condition and					
		ne to treat her. She stated					
		pain something obviously					
		e was swelling and bruising.					
		s independent in her room					
		o the falls but after the falls she				1	

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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2 265	Continued From pa	age 12	2 265			
	2 assist. She stated called back on 6/18 back and told abou swelling and chang when they faxed or should have called her in for an x-ray t bruising on the 17th right which should I stated we have pain have used to make the Tylenol was obv control. During interview wit 8/14/18, at 3:22 p.m been notified of the of the ankle. He stathe morning it happ see the fax from the 18th. At that time and asked if everyt not hear anything b asked for an x-ray of Review of the polic 11/2016, indicates to consult with the rest a significant change mental or psychoso treatment significant change an existing commence a new f R24 R24's quarterly Min 6/1/18, indicated R2 impairment and rect	y Notification of Change dated the facility must immediately sidents physician when there is e in the residents physical, ocial status and a need to alter ntly - a need to discontinue or form of treatment or to				

Minnesota Department of HealthSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE			
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2 265	Continued From pa	lge 13	2 265				
	R24's Medication Administration Record (MAR) dated August 2018, identified R24 received aspirin 81 milligrams (mg) on a daily basis. R24 was interviewed on 8/6/18, at 3:30 p.m. and explained he developed a bruise on his left arm,						
		some occasional pain. R24 le obtained the bruise, and fe r in size.	lt				
	R24 had bruising o interventions for the monitor the location	n initiated 7/31/18, indicated n their left upper arm with e staff to follow including to n and size of the bruise, and s and/or lack of healing to the	9				
	R24 developed a b measured 15 centil	rt dated 7/30/18, identified ruise on his left arm, which meters (cm) by 14 cm in size as saying, "it hurts."					
	R24's progress not entries:	es identified the following					
	"Large discolored a dark in color and ye arm. Resident says Etiology unknown." physician progress	as recorded as having a, irea on left upper arm that is ellowish towards the posterior s, 'My whole arm hurts' Later on 7/30/18, R24's note identified R24 had beer an for the bruising who nitor the area.					
	appears slight swol	pper arm is discolored and len. He did not acknowledge er as he did yesterday."					
nnesota De	On 8/5/18, "Update epartment of Health	on impaired skin integrity.					

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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	Continued From pa	-	2 265			
	that it had spread d Swelling noted arou bruising towards the lightening up, startin He states he has no extends and brings moderate pain. Ice is being managed v continue to monitor					
		m bruising noted that it had ire arm. Swelling noted aroun pain."	d			
	in the hallway in a w to his room, and reg assisted him to rem yellow bruising on h extending down his inches, followed by black colored, bruis around R24's left at the top of the left ha left arm was swolle swelling in the elbor his right arm. RN-E bruise when it was report, however, ex	on 8/8/18, at 7:00 a.m. seated wheelchair. R24 was assisted gistered nurse (RN)-D hove his shirt. R24 had visible his front upper shoulder arm approximately three dark purple, at times almost sing extending down and rm and wrist area, covering and. In addition, R24's entire n with noticeably localized w region when compared to D stated she had observed the first identified on the incident plained she was not aware if d R24's physician about the s first identified.	•			
	stated she was awa arm, and he had be	a.m. nursing assistant (NA)-A are R24 had bruising on his le een complaining of pain when o push himself up in bed durin	ft			
	On 8/8/18, at 8:25 a	a.m. registered nurse (RN)-A				

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2 265	Continued From pa	age 15	2 265			
	ago" and she was r gotta work its way of expressed she was had been notified of developed, howeve or that current inter On 8/8/18, at 8:44 a R24's medical doct the facility to notify including when brui so treatment could On 8/8/18, at 9:00 a (DON) stated she e physician when the change, which was a natural gravity ch	"appeared a couple of weeks not concerned with it as, "It's down but its fading." RN-A s unaware if R24's physician of the bruising since it er, did not feel it had worsener ventions were not working. a.m. during a phone interview for (MD)-A stated he expected him of changes to a resident ising and/or swelling changed be considered. a.m. the director of nursing expected staff to notify the by identified a significant "something that is more than ange." The DON stated MD- o the facility today to observe	d /, 1			
	interview, MD-A sta left arm bruising an ice to be applied. M expected to have b A Notification of Ch identified the staff s	2 p.m. during a follow-up ated he had observed R24's id ordered an ACE wrap and MD-A stated he "would have een notified of this change." hange policy dated 11/2016, should consult with the				
	change in their phy status. SUGGESTED MET The DON or design policies and proced	n when there is any significan sical, mental or psychosocial FHOD OF CORRECTION: nee could develop and monito dures to ensure practioners an in residents condition	or			
	accurately. The D	ON or designee could educat on these policies and	e			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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		00085	B. WING		08/	10/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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2 265	Continued From pa	age 16	2 265			
	procedures. The Demonitoring systems compliance.	ON or designee could develop s to ensure ongoing				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty one				
2 800	MN Rule 4658.051 Staffing requirement	0 Subp. 1 Nursing Personnel; nts	2 800			9/19/18
	home must have of number of qualified registered nurses, I nursing assistants residents at all nurs in all buildings if mo	prequirements. A nursing n duty at all times a sufficient I nursing personnel, including licensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends, cements.				
	by: Based on observative review the facility farmer facility farmer facility farmer for the facility farmer for the facility farmer for the facility for the facility for the facility for the for the for the for the facility of the facility for	ent is not met as evidenced ion, interview and document ailed to provide sufficient vide and meet assessed sidents (R48) reviewed for of 1 resident (R41) reviewed residents (R16) reviewed for sident (R7) reviewed for dents (R4, R48, R54) reviewed y living (ADLs); and 1 of 1 ewed for position mobility. In dents (R16, R39, R58), 1 of 3 M-G), and 6 of 6 staff PN-A, TMA-A, NA-D, NA-H, rns with the lack of sufficient facility. The lack of sufficient the potential to affect all 70		Corrected		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00085	B. WING			C 10/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
		705 SIXT	H STREET			
GOOD S	AMARITAN SOCIETY	- WINDOM WINDOM	I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 17	2 800			
	residents in the fac staff.	ility along with visitors and				
	Findings include:					
	Pressure Ulcers:	Pressure Ulcers:				
	implemented. On 8 observed from 7:15 recliner in the dining other residents in a providing breakfast one leg on the footr other leg hanging d shoe on. R48 woul and would make m At 9:38 a.m., nursir approached R48 ar up; the resident res NA-F pivot transfer (w/c) which had a p cushion on the sea not have a pressure seat. NA-D then pr to be toileted. NA-I (NA-J) had already cares earlier when 6:00 a.m. (approxin NA-F stood the res R48's bottom was or red areas, one on t upper buttock near circular and approx	nterventions were not 8/8/18, R48 was continuously 5 a.m. until 9:38 a.m. lying in a g area. Staff were assisting and out of the dining room and c during that time. R48 had rest of the recliner with the lown with one shoe off and one ld move his legs periodically oaning/humming type sounds. Ing assistant (NA)-D and asked if he was ready to ge sponded he was. NA-D and red R48 into his wheelchair oressure reducing waffle air t. The resident's recliner did e reducing cushion on the ropelled R48 into the tub room D indicated the night aide completed R48's morning assisted with toileting around nately 3 1/2 hours earlier). Insferred R48 onto the toilet. shed with toileting, NA-D and ident up to provide peri-care. observed to have 2 small open he coccyx and one on the right the crease; the areas were simately 0.5 centimeters (cm) asked if the areas were new,	t			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00085			С	
		00085	B. WING			10/2018
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	′ - WINDOM	TH STREET 1, MN 56101			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	age 18	2 800			
	alerted the nurse to observe the resider nurse (LPN)-B enter confirmed R48 had LPN-B stated the a would have to rese record to make sur to today. LPN-B th the resident breakf treatment or measu interviewed immed observation, NA-D the recliner in the of the resident first ca attempt to have him room as the reside R48 would crawl of and come out to th sleep. Per R48's p	ck down onto the toilet and o come into the tub room to nt's bottom. Licensed practica ered the tub room and d 2 open areas on his bottom. areas were new to her but earch the resident's medical re they had not been there prio ten instructed the NA's to feed ast first prior to providing uring the open areas. When liately following the confirmed R48 always slept in dining area. NA-D stated when ame to the facility they would in sleep in the recliner in his nt slept in a recliner at home. ut of the recliner in his room e recliner in the dining area to oreference, they continued to the recliner in the dining area.	r			
	stated staff try to re though sometimes stated sometimes t	on 8/8/18, at 10:27 a.m. NA-D eposition R48 every 2 hours it can be longer. NA-D further the resident was resistive to id other days he was up and or				
	a.m. indicated: Ha May we have an or open area. Chang becomes dislodged	ated 8/8/18, and sent at 11:34 s an open area on his coccyx. rder to read Hydrocolloid to e q (every) 5 days or when it d or soiled. Fax was returned 3 at 10:07 a.m. with physician er.				
	in recliner in the dir	p.m. R48 was observed laying ning room with knees bent and n interviewed at that time NA-D				
	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 08/10/2018	
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		00085	B. WING			
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		H STREET			
			, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 800	Continued From pa	age 19	2 800			
	recliner at approxim confirmed LPN-B h any type of treatme bottom as was awa registered nurse ca When interviewed stated she had app the open area on F the dressing was la smaller superficial coccyx as well. W open area on R48' stated not realizing one open area. LF back to work tomo it then. LPN-B con the open area on F having a difficult tin standing during the open area on the oc cm round in diame	dent was transferred into the mately 12:50 p.m. NA-D furthen had not yet measured or done ent to the open areas on R48's aiting direction from the ase manager (RN)-C. on 8/8/18, at 1:57 p.m. LPN-B blied a hydrocolloid dressing to R48's coccyx. LPN-B stated arge enough to cover the reddish areas below the hen asked about the other s right upper buttock, LPN-B g the resident had more than PN-B then stated she would be rrow morning and could look at firmed she had not measured R48's coccyx as staff was ne keeping the resident e treatment. LPN-B stated the coccyx was approximately 0.5 ter. LPN-B confirmed R48 had essure reducing cushion when				
	observed getting R perform morning c standing lift to tran w/c had a pressure the seat with very I recliner did not hav on the seat. R48 w room to be toileted utilized the standin onto the toilet, NA- was soiled with boy	a.m. NA-H and NA-D were A48 up out of his recliner to ares. The NA's utilized a sfer R48 into his w/c. R48's e reducing waffle air cushion on ittle air in the cushion; the ve a pressure reducing cushion was then propelled into the tub and assisted with cares. NA's g lift to transfer the resident H removed R48's brief, which wel movement. NA-D asked a duoderm dressing on the				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		С	
		00085	B. WING			0 10/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET , MN 56101			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	age 20	2 800			
	changing clothes for then raised the rest with the lift and pro- out "Ow!" while his R48's bottom was of dressing covering t two open areas on area on the coccyx observation on 8/8/ the coccyx was large the wound bed. The buttock near the cre- was reddened and was another small put the call light on entered the room a on R48's coccyx. The coccyx measured the lower open area med LPN-A also identified on R48's right buttor scratches. LPN-A also identified on R48's right buttor scratches. LPN-A also identified on R48's right buttor scratches. LPN-A also were no new interviewed of stated R48 was to b just like all the other When interviewed of stated he was told of that RN-C wanted b R48's bottom as it b an open area. LPN were no new interviewed of states of the states of the sta	isting R48 with washing up and or the day, NA-D and NA-H ident up to a standing position vided peri-care. R48 hollered bottom was being cleansed. observed; there was no he resident's coccyx. R48 had the coccyx, the upper open was new since the (18. The lower open area on ger with white slough covering he area on the right upper ease had decreased in size, appeared to be closed, there reddened area next to it. NA's to alert the nurse. LPN-A and measured the open area's The new upper area on the 1.0 cm and was circular, the easured 1.8 cm x (by) 1.0 cm. ed the small reddened areas ock though felt they were applied skin prep to R48's ed the open areas with a ng. NA-H then finished ransported him to the dining on 8/9/18, at 10:49 a.m. NA-E be repositioned every 2 hours er residents on the unit.				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED					
					С						
		00085	B. WING		08/	10/2018					
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE							
GOOD SAMARITAN SOCIETY - WINDOM 705 SIXTH STREET WINDOM, MN 56101											
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)					
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE					
2 800	Continued From pa	age 21	2 800								
	stated LPN-B had n area on the coccyx area due to the res though was able to duoderm dressing. updated R48's care was to be repositio after meals, for the afternoon, and at H approximately ever RN-C stated in the R48 had his eyes of RN-C further stated was resistive, they also implementing cushion to be utilized the recliner as well to this a pressure r utilized in R48's red necessary as the red RN-C confirmed the should have been on night and was not s further confirmed F been replaced whe should be monitorin air cushions were of RN-C stated LPN-A as he also worked When interviewed of confirmed R48's pr cushion was on the needed more air in nursing's responsite and make sure the LPN stated when the	on 8/9/18, at 10:59 a.m. RN-C reported R48 had an open , was unable to measure the ident becoming uncooperative cover the area with a RN-C stated she had e plan indicating the resident ned once awake, before and 3:00 p.m. activity in the IS (bedtime). RN-C confirmed y 2 hours as R48 allowed. morning staff usually wait until open and was ready to get up. d staff do not push it and if R48 let him sleep. RN-C stated R48's pressure reducing ed when the resident was in as the w/c. RN-C stated prior educing cushion had not been cliner as did not think it ecliner cushion was soft. e pressure reducing cushion utilized in R48's recliner last sure why it was not. RN-C R48's dressing should have en the old fell off and that staff ng when the pressure reducing deflating and needed more air. A was usually the one to do this as a restorative therapy nurse. on 8/9/18, at 1:48 p.m. LPN-A ressure reducing waffle air e low side and definitely it. LPN-A stated it was oility to monitor the cushions y were inflated adequately. he next shift came on at 2:30 e them take the cushion down	3								

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:		С	
		00085				08/10/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET M, MN 56101			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	age 22	2 800			
		lated and to pick up an extra the resident's recliner.				
	8/9/18 by LPN-A ide the coccyx as mois When interviewed of 10:00 a.m. RN-C co visualized R48's op could not say for su associated or press confirmed an RN h areas.	and Data Collection dated entified R48's open areas on sture associated wounds. on 8/10/18, at approximately onfirmed she had not yet ben areas on the coccyx and ure if they were moisture sure wounds. RN-C further ad not assessed R48's open				
	RN-C and the direct confirmed R48 had	on 8/10/18, at 10:38 a.m. ctor of nursing (DON) I two stage 2 pressure ulcers a small 0.5 cm open area on ock.				
	DON provided door were to follow when discovered. DON s to notify the RN case fax the physician of the RN case mana- as soon as she cou- the appropriate trea DON reviewed R48 Collection Tool date of the tool did not a sleep in bed and w time therefore shou differently in terms confirmed a Positio Evaluation had not determine an indivi schedule. DON co	on 8/10/18, at 10:54 a.m. the umentation of the process staf n a new skin issue was stated she would expect staff se manager right away and to f the skin issue. DON stated ger should evaluate the area uld to assess and to provide atment and interventions. B's Mobilization Support Data ed 6/28/18. DON stated much apply to R48 as he did not as on his seat much of the uld have been looked at a little of positioning. DON oning Assessment and been completed for R48 to idualized repositioning onfirmed when R48 no longer care plan should have been				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING			C 08/10/2018	
AME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
	AMARITAN SOCIETY	705 SIXT	H STREET				
3000 5	AMARITAN SUCIETY	- WINDOM WINDOM	I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 800	Continued From pa	ige 23	2 800				
	reducing cushion to DON stated with re how well R48 slept like and go from the every hour and a ha far as how often to resident was sleepi had a good cushior completed by physi that had not been of confirmed staff sho appropriate amoun utilizing. DON confi completed an asse first identified. DOI interventions for resplan and it will com transfer to the kard on the kiosk - there written at the statio the NA's should ha in his recliner once plan.	have expected a pressure be utilized in the recliner. positioning would need to see and what that pattern looked ere, though would start with alf to 2 hours repositioning. As reposition at night if the ing would depend upon if he n and had pressure mapping ical therapy. DON confirmed completed for R42. DON uld be monitoring for the t of air in the cushion R48 was firmed an RN should have ssment on the wound when N stated when there are new sidents' it will go on the care e out with a "k" and that will ex so the NA's can see them a was also a 24 communication in for staff as well. DON stated ve known to utilize the cushion implemented into the care	1				
	SEE F686 FOR AD Pain Management	DITIONAL INFORMATION					
	timely manner to tr fall that resulted in incident report date identified staff went knocking since resi 5:30 a.m. as per us the floor next to the Walker next to her.	led care and services in a reat an injury resulting from a a fractured ankle. Review of ed 6/16/18, at 5:40 a.m. t into R16's room after dent did not put on call light at sual. R16 was found sitting on e bathroom door frame. R16 stated she didn't know eft foot tender to touch, no					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00085	B. WING			C 08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET , MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 24	2 800				
		er assessing ankle, no ove ankle back and forth, up					
	a.m. identified resides bathroom as she h wheeled R16 into the grab bar to stand u out of the room so suddenly let self sli witnessed. The rep cause of the fall ma foot was hurting sime earlier. R16 was a	report dated 6/16/18, at 7:25 dent was taken to the ad her call light on. Staff he bathroom. R16 used the p. Staff moved the wheelchair to help resident. Resident p to the floor. The fall was bort also identified the root ay have been that R16's left her she had fallen 2 hours ssisted with the mechanical lift d. Pain rating was identified					
	6/16/18, 7:36 a.m. and sent to WAH (I	notes are as follows: Urine specimen was obtained local hospital) for U/A (urine order. Urine is cloudy and					
		Ice pack for swelling to left is as needed apply to left ankle g pain in left ankle.					
	hours. Alert but co since 10 p.m. last r a.m. as was check were no screams o that there was no c	Resident fell twice within 2 nfused, states "I laid there night". She was in bed at 3:30 ed by this writer (staff). There coming from room as evidence obvious way she sat there all t affect, and skin had no					
	reddened areas of painful after admini mg. Called primary urine is very foul ar	pressure. Left ankle was still istration of PRN Tylenol 650 y doctor since she is confused, nd incontinent of urine times 2 Jsed mechanical lift both times					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00085	B. WING			C 10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
	AMARITAN SOCIETY	705 SIXT	H STREET			
GOOD 3.	AMARITAN SOCIETY	- WINDOM WINDOM	I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 25	2 800			
	bathroom, hung on remove the wheelc	or. Resident stood up in to grab bars until writer could hair to assist her to pivot onto , she went down slowly on her				
	phoned Dr. to inform ankle, no swelling a urine has a foul odd (orders were for UA 6/16/18, 8:15 a.m., ankle and was brow breakfast. Has no addresses tablema 6/16/18, 9:06 a.m. ankle every 4 hours ankle for swelling F administration was hurts.	Applied ice pack to left outer ught to dining room for complaints of pain while te's at breakfast. Ice pack for swelling to left s as needed. Apply to left				
	regarding UA, orde given one dose it w allergy, call MD info medication. He sta shouldn't be a prob changed to Macrob	red Cipro, after resident was vas noted that she had an ormed him she had allergy to ated no concern and it lem, just watch her. MD then oid 100 mg twice daily for 7				
	weight on left ankle stand times two as Left ankle not swoll	Due to not able to bear full after her fall, now using sit to sist to use bedside commode. len but is painful. Applied ice				
	(electronic long tern for an order to med 6/17/18, 12:04 a.m mg give by mouth e	 ea. Call placed to eLTC m care Dr. available via video) licate with PRN Tylenol. Acetaminophen tablet 650 every 4 hours as needed for nen not to exceed 3,000 mg 				
	per day. Contact p	rovider/practioner if fever is rt in left ankle, rates 5 out of				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			C
		00085	B. WING	B. WING		10/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		TH STREET A, MN 56101			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	age 26	2 800			
	ankle, every 4 hour	. Ice pack for swelling to left is as needed. Has ice pack to en but is very tender to touch.				
	pain in left ankle. (falls 6/16/18. Spok	. Phoned eLTC in regards to Change of condition after her te with (eLTC staff) about no . Will receive orders via fax.				
	6/17/18, 1:23 a.m. and effective. Follo	Acetaminophen was given w up pain score 5.				
	6/17/18, 2:32 a.m. ankle.	Ice pack for swelling to left				
	edge of bed as writ resident to rate her said feels better tha	Resident was sitting up on er (staff) went by. Asked pain, stated it's better now, an yesterday. Able to bear full left foot. Transferred with sit m				
	6/17/18, Acetaminc general aches.	ophen 650 mg given for				
		Ice pack for swelling to left ain in left ankle as 8 out of 10.				
	6/17/18, 6;05 a.m. it feels the same.	Ice pack for swelling. Stated				
		Acetaminophen 650 mg ineffective pain scale was a 5				
	can stand on my le sit to stand lift put r	Resident stated I don't think ft leg. When transferred with nost of weight on that leg with r complaints. Denied pain				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00085	B. WING			C 08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET 1, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 27	2 800				
	stated it's a little so	re.					
		Resident stated right ankle le bruise on inner right ankle. nitor.					
		Acetaminophen 650 mg given le to bear weight on both legs inful."					
	6/18/18, 2:12 a.m. ankles.	Ice pack applied to both					
	and can't stand on stand lift for transfe that leg with no fac	Stated "i hurt my right ankle my leg". When placed in sit to er placed most of weight on ial grimace or complaints. Has inner right foot. Stated its a elling bilateral feet.					
	6/18/18, 2:48 a.m. ankle. Took the pa	Ice pack for swelling to left tchiness away.					
		Acetaminophen 650 mg 9. Resident stated no relief to pain.					
		Resident complained of in, requesting analgesics.					
	6/18/18, 8:29 a.m. stated no relief fror	Pain scale 10. Resident n pain.					
		Acetaminophen 650 mg omplained of severe right leg					
		Acetaminophen 650 mg PRN ineffective. Pain scale 10 having any relief.					

STATE FORM

If continuation sheet 28 of 102

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		BENTI IO/TION NOWBEN.	A. BUILDING: _				
		00085	B. WING			C 08/10/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
OOD S	AMARITAN SOCIETY	- WINDOM	H STREET I, MN 56101				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 800	Continued From pa	age 28	2 800				
	6/18/18, 8:03 p.m.	Acetaminophen 650 mg given.					
		. Acetaminophen 650 mg ve pain scale 5 still hurting					
	right foot which nov ankle and top of foo two days. Rather	. Very painful when assessing w is bruised entirely around the ot is swollen more than last than bear weight on it will use /ill get X-ray tomorrow.					
	to void tonight since in both feet. Now t assist to raise up o chux. Resident wil much pain to move	Has been using the bed pan e she is having so much pain otal lift of mechanical lift with 2 ff the bed to change soiled I not turn, insists she's in too e. Medicated with PRN Tylenol 50 mg for severe discomfort.					
	resident needs to b	Pain is so extreme that the be raised in bed using ted a bruise on under side of					
	assist out of bed wi swollen +2 and bru	Has a whirlpool bath. Two ith sit to stand lift. Right foot is ised Did have a lot of pain om bed to wheelchair.					
		Acetaminophen 650 mg was cale 8. Resident continues to					
		faxed MD questioning if needs ted to swelling, bruising and f 6/16/18.					
	6/19/18, 2:41 p.m. epartment of Health	Fax received from MD that					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING			C 08/10/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
OOD S	AMARITAN SOCIETY	- WINDOM	H STREET , MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	YTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	ige 29	2 800				
	may obtain x-ray of	right foot/ankle.					
		nily member and informed of nkle scheduled at hospital for n.					
	6/19/18, 8:10 p.m. for ankle pain.	Acetaminophen 650 mg given					
	6/20/18, 12:19 a.m	. Asleep at this time.					
		Acetaminophen 650 mg mplained of severe right ankle					
		Acetaminophen 650 mg. ineffective. Pain scale 8. ving no relief.					
		. Resident left at 10:45 to get Resident left in wheelchair.					
		Acetaminophen 650 mg given. ed of moderate pain in right analgesics.					
		Resdient arrived back at p.m. Right ankle was splinted.					
	and stated not so b	Discussed pain with residnet ad mostly hurts when I lie rs on it. Stated splint supports fortable.					
	6/20/18, 8:18 p.m. for pain scale of 4.	Acetaminophen 650 mg given					
	6/21/18, 3:10 a.m. given.	Acetaminophen 650 mg					

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IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET 1, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 800	Continued From pa	age 30	2 800				
	6/21/18, 6:17 a.m. not effective. Pain	Acetaminophen 650 mg was scale 8.					
	6/21/18, 8:15 a.m. ankle.	TO hospital for surgery right					
	she had right ankle in a wheelchair. Ri	Returned from hospital where e repair about 6:30 p.m. She is ight foot is splinted and Rates pain at 8 of 10. Will ods arrive.					
	6/21/18, 8:30 p.m. pain level of 8.	Given Ketorolac 10 mg for					
	identified nurse cal for pain. Patient re had an order for ice medication. At this	C dated 6/17/18, at 1:00 a.m. led requesting order for Tyleno cently sprained her left ankle, e but no order for pain time Acetaminophen 325 mg hours PRN pain was ordered.					
	The fax identified F walking to the bath ROM (range of mo putting pressure or want to stand on le was faxed back to p.m. with physician this, I assume all is noted as received I	ne MD on 6/16/18, at 5:40 a.m. R16 was found on the floor room with 4 wheeled walker. tion) to left ankle painful when n foot, no swelling. Does not ft ankle. No bruising. The fax the facility on 6/18/18, at 12:20 comment, "I was called about a now well. Yes? The fax was back at facility 6/18/18. No ne physician regarding pain at ankle.	,				
		/ results dated 6/20/18, type B distal fibular/lateral or the right ankle.					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	′ - WINDOM	H STREET I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 31	2 800				
	identified pain asso condition, non-phan ice and rest. The a current medication mg and ice PRN w During interview w (DON) on 8/9/18, a should have been i timely way than fax was done as far as effective, pain statu what was being do with complaints of changed since ther She stated R16 wa with walking prior to needed to be trans 2 assist. She stated called back on 6/18 back and told abou swelling and chang when they faxed or should have called her in for an x-ray to bruising on the 17th right which should stated we have pai have used to make the Tylenol was ob- control. During interview wi 8/14/18, at 3:22 p.r been notified of the of the ankle. He st the morning it happ see the fax from th	sessment dated 6/18/18, bociated with a diagnosis or rmacological interventions of assessment also identified the regime of PRN Tylenol 650 as not working. With the director of nursing at 10:24 a.m. she stated staff in touch with the Dr. in a more king. She verified no follow up a pain medication not being us, change in condition and ne to treat her. She stated pain something obviously re was swelling and bruising. as independent in her room o the falls but after the falls she ferred with mechanical lift and d the MD should have been 8/18, when we received the fax at the increased pain and ge in condition. She stated in the 19th about an x-ray they and not faxed the Dr. to get that day. She stated they saw h, first on the left then on the have been addressed. She in meds in the e kit we could e her more comfortable since viously not working for pain the the attending physician on m. he stated he should have e increased pain and swelling tated he was notified of the fall bened. He stated he did not the 16 until Monday morning the he stated I responded back					

	<u>ta Department of Herror Department of Herror Department of Deficiencies</u> OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
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IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET			
			I, MN 56101	PROVIDER'S PLAN OF		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 32	2 800			
		thing was ok. He stated I did back from them until they on the 19th.				
	11/2016, indicates consult with the res a significant chang mental or psychoso treatment significant	ey Notification of Change dated the facility must immediately sidents physician when there is e in the residents physical, ocial status and a need to alter ntly - a need to discontinue or form of treatment or to form of treatment.	;			
	Hospice Coordinat	ion:				
	for R41. R41's med certification/recertificati	o coordinate hospice services dical director fication dated 6/7/18, identified care date of 3/18/18, with degeneration of the brain.				
	identified R41 had and total depender	nange MDS dated 3/23/18, a severely impaired cognition nce in all activities of daily lso identified R41 was services.				
	a terminal prognos dementia and was Interventions includ coping skills, conta	vised 4/3/18, identified R41 had is related to end stage receiving hospice care. ded, assess resident and family act hospice staff for support as nursing staff to provide for the resident.	y			
	numerous papers of facility staff! R41 is hospice). The tear	ons on a clip board under was a paper that said attention s under the care of (name of m was identified as nurse, chaplain. No aide or volunteer				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET I, MN 56101				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLET	
2 800	Continued From pa	age 33	2 800				
	on that said (name visits on Monday, A Monday thru Friday Thurs/Fri. No patie paper nor are times care provided by th visit schedule on it. During observation hospice aide was p 7:43 a.m. R41 was being fed by a staff after giving R41 he	on 8/8/18, at 7:05 a.m. present giving R41 a bath. At sitting at the breakfast table f member. Hospice aide left r bath.					
		on 8/9/18, at 7:47 a.m. present feeding R41.					
	assistant (NA)-D st are going to do who today they couldn't go do something el a bath and feed he her. We never kno times they come ei sometimes they do to come 3 days a w maybe only come t time. sometimes it supposed to be her	a 8/8/18, at 8:13 a.m. nursing tated we don't know what they en they come. For instance feed her because they had to lse. Sometimes they give her r, sometimes they just feed ow. We don't know days or ther. Sometimes they tell us n't. I think they are supposed week or something but they wo. We never know what t's 6 a.m. when they are r at 8, we never know. They 4 in the afternoon before too.					
	stated you never ki come. Sometimes to leave because th else so they don't c	n 8/8/18, at 8:30 a.m. NA-F now around here when they wil they come and then they have ney have to go somewhere to everything they are y can't make it they don't tell us ther day.)				

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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE	
2 800	Continued From pa	age 34	2 800				
	stated well there is aide comes every Friday between 6 a chaplain and a soc of the week. The r was here yesterda comes a lot. If they they just come and are stable so I'm n do let the nurse kn aides should be to During interview or practical nurse (LF where the calenda know when they ca stated the calenda During interview or aide (HA)-A stated for R41. She state have another patie aides and we all ha depends on where	n 8/8/18 at 9:28 a.m. licensed N)-B stated she did not know r for hospice was located to ame. RN-B came onto unit and r is under the clip board. n 8/09/18, at 7:47 a.m. hospice we are here 5 days per week ed I come at 5:30 because I nt here. We have 5 different ave different schedules. It the clients are and who has	1				
	cares then I don't f care then I feed he her hair. Normally her. Yesterday I ha	ney come. If I do morning eed and if I don't do morning er breakfast, play music, curl her bath is done so then I feed ad to go because we were	1				
	up so I had to go. staff really unless s just come in and g need to tell them s	led in so we had to split visits She stated I don't talk to the something out of the ordinary. o to her room and help her. If omething I will, like if					
	During interview o stated the hospice	ent or out of the ordinary. n 8/9/18, at 12:47 p.m. she should give us a schedule. om we don't know when their					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		TH STREET A, MN 56101			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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2 800	Continued From pa	ige 35	2 800			
	people are coming. communication for					
	Edema:					
	retention) R7 with e diagnosis report da diagnoses of edem	o monitor edema (fluid edema in feet/ankles. R7's ted 8/10/18, included a, macular degeneration (an uses vision loss), and				
	6/12/18, included L	rent physican orders dated asix (a medication to reduce dy) 80 milligram (MG) daily for	r			
	was observed to ha and ankles. The re- chair in her room w The resident had ve socks on, however to R7's ankles from	on 8/8/18, at 12:50 p.m., R7 ave bilateral edema in her feet esident was sitting in a recliner rith her feet resting on the floor elcro closing shoes and grippy there was visible indentation of the grippy socks. The right ddened appearance.	r.			
	nursing assistant (recliner chair. R7 however visible bila	on 8/9/18, at 8:46 a.m. NA)-C transferred R7 into a was wearing socks and shoes ateral edema to ankles was remained on the floor when	·,			
	confirmed R7 had e further stated there	8/8/18, at 10:04 a.m. NA-C edematous ankles. NA-C were no specific interventions ndicated R7 would elevate her o.				
	During interview on	8/8/18, at 1:09 p.m.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00085	B. WING	B. WING		10/2018
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY		TH STREET M, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 36	2 800			
	standing edema to	RN)-B indicated R7 had long her lower extremities. RN-B as no formal monitoring in a.				
	2:22 p.m., R7 was her feet on the gro lower extremities s RN-C further verifie redness present bu noted from R7. RN pitting edema (swe to cause an indenta the skin when depr ankle and foot and (indentation of 2 m foot. RN-C stated support stockings i R7 should have oth	and interview on 8/9/18, at sitting in her recliner chair wit und. RN-C assessed R7's stating they were cool and dry. ed right lower extremity had a ut no warmth or discomfort N-C identified R7 had two plus elling that is significant enough ation of 3-4 millimeters deep in ressed with a finger) in right one plus pitting edema illimeters) in left ankle and I R7 had refused to wear in the past, however indicated her interventions in place to tor the edema, confirming the ce at this time.	S 1 in			
	director of nursing	n 8/10/18, at 2:48 p.m. the (DON) confirmed R7's lower hould be monitored with ace to control it.				
	Activities of Daily L	.iving (ADLs):				
	shaving. R4's care the resident require personal hygiene.	assistance with nail care and plan reviewed 8/7/18 indicate ed assistance of 1 staff with The care plan further identifie e if R4 was exhibiting ares.				
	During observation	n on 8/6/18, at 1:56 p.m. R4				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00085	B. WING		08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET , MN 56101			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	age 37	2 800			
	was noted to have long soiled fingernails and long white hair on her chin.					
	7:16 a.m., R4 conti chin hair. Nursing R4's long dirty finge you'd let us trim you pleasant and coope	of morning cares on 8/8/18, at nued to have long nails and assistant (NA)-D looked at ernails and stated "oh I wish ur nails". Though R4 was erative with transfers, dressing was no attempt to trim nails, provide oral care.				
	was observed in the	on 8/08/18, at 2:43 p.m. R4 e dining room feeding herself vith long dirty nails and long				
	10:19 a.m., R4 con chin hair. NA-E st mood" and it was a Though R4 was ple transfers, dressing	of morning cares on 8/9/18, at tinued to have long nails and ated R4 was in a "wonderful good time to complete cares. easant and cooperative with and toileting, there was no al cares or nail care.				
	and NA-E confirme care, shaving, or na cares. NA-D furthe assistance with the	a 8/9/18, at 1:23 p.m. NA-D of they had not offered oral ail trimming to R4 with morning er indicated R4 required se grooming tasks and ong fingernails and chin hair.				
	registered nurse (R fingernails and chir "goatee". RN-C ind will refuse cares, he should be offered c	8/9/18, at 2:09 p.m. N)-C confirmed R4 had long hair which she described as a dicated R4 has behaviors and owever oral care and shaving laily before breakfast, and cleaned when R4 allows.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
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		00085	B. WING	B. WING		08/10/2018	
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE			
iood s	AMARITAN SOCIETY		TH STREET M, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 800	Continued From pa	age 38	2 800				
	(DON) stated her e trim nails and provi breakfast. The DO gotten R4 a new ra would expect staff tasks when she wa R54 was not provic R54's care plan las self care performar hemiparesis and in dress, or groom. T R54 with several na Interventions includ	2 p.m. director of nursing expectation is for staff to shave de oral cares prior to N further stated she had zor about one week prior and to reapproach or complete is cooperative if refused. Ned assistance with oral care. It revised 7/4/18, identified a noce deficit related to left ability to independently bathe. The care plan further identified atural teeth broken off. Ned staff assistance with nd assist to brush teeth after	,				
	11/7/17 indicated e	ea assessment (CAA) dated xtensive to total assist was s due to hemiplegia.					
	member- A stated s	8/6/18, at 7:14 p.m. family she frequently notices food th and questioned if his teeth d twice daily.					
	room in a Broda ch not been brushed.	a.m. R54 was sitting in his air. He indicated his teeth ha An oral care basin, including s observed in the medicine sink in R54's room.					
	sleeping in his bed.	a.m. R54 was observed to be . The oral care basin was me location with a dry					
	On 8/8/18, at 1:19	o.m. toothbrush remained dry					

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AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
OOD S	AMARITAN SOCIETY		H STREET I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
2 800	Continued From pa	age 39	2 800				
	stated oral cares a residents up in the confirmed she had morning stating sh On 8/10/18, at 3:02	2 p.m. director of nursing expectation is for staff to					
	and eating. R48's indicated the reside required extensive	ded assistance with oral care care plan dated 7/7/18, ent had his own teeth and assistance of one staff with ares to be performed BID (twice s.	9				
	member (FM)-G st	on 8/6/18, at 4:17 p.m. family ated feeling R48's mouth had at times and wondered if staff					
	and NA-H were ob cares for R48. NA recliner where he s wheelchair (w/c) vi propelled R48 into then transferred R4 toilet. NA-D donner resident with wash hands and fingerna obtained a clean w washed and dried swishing his mouth NA-D asked R48 if a towel up to his m	a.m. nursing assistants (NA)-D served providing morning 's transferred R48 from the slept in the dining area, into his a a standing lift. NA-H then the tub room. NA-H and NA-D 48 via the standing lift onto the ed gloves and assisted the ing his face then cleaned his ails thoroughly. NA-D then ashcloth and towel and R48's underarms. R48 was a as if he had food or liquid in it the needed to spit and brought outh but the resident wouldn't her gloves and obtained)				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00085	B. WING			C 10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
		705 SIXT	H STREET			
3000 5	AMARITAN SOCIETY	- WINDOM WINDOM	l, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 40	2 800			
	up and provided per licensed practical r room and complete after pericare was completed the trea dressing R48 and t NA-H then brought	nd NA-H then raised resident ericare; during that time hurse (LPN)-A entered the tub ed a treatment to R48's bottom completed. Once LPN-A tment, NA's then finished with transferred him into his w/c. R48 out to the dining room for s not offered/provided oral				
	registered nurse (F related to oral care twice a day. RN-C	on 8/9/18, at 10:59 a.m. RN)-C stated the expectation was as the resident allowed further confirmed staff should R48's teeth rather than using				
	7/24/18, indicated t assist of one staff v resident with a calr with adequate eatir	A48's care plan, last revised the resident required extensive with eating, and to provide the n, quiet setting at meal times ng time. The care plan further s liquids/food in mouth and o swallow.				
	observed seated in dining room table in supper meal; R48's At 6:00 p.m. nursin R48 and asked him was assisting anoth at that time. NA-G was on his plate; th wrapped up in his of At 6:05 p.m., licens	p.m. R48 was continuously his wheelchair (w/c) at the n Heritage Court during the s meal was served at that time. g assistant (NA)-G addressed h if he was going to eat, NA-G her resident at the same table showed R48 that his spoon he resident had his hands clothing protector at that time. sed practical nurse (LPN)-C				
	were mixed in pude	administer medications that ding. With assistance from tually was able to administer				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET , MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	the medications in prequired verbal propriet verbal propriet wallow the medications in his mouth. The read of the pudding that the R48 still had not ear assistance. The read still had not ear assistance. The read that still had not ear assisted the resident had alread that time. R48 accurates approximately 50% NA-K got up from the meal in the microwa front of R48. NA-K with eating his mear resident. At 6:55 privith a bite of potator set it back down on observed to eat any he had been assisted When interviewed of stated R48 usually not having any of it would check with the would eat a snack. On 8/9/18, at 9:49 are observed to prepare R48. LPN-A placed then continued to proom; LPN-A did not eating. At 9:51 a.m. going to try his bread to the prevent the state of the prevent to prevent to the prevent to prevent to the prevent to the prevent to prevent the prevent to prevent the prevent to prevent to prevent the prevent to prevent the prevent to prevent to prevent to prevent to prevent the prevent to prevent to prevent the prevent to prevent the prevent to prevent to prevent the prevent to prevent to prevent the prevent to prevent to prevent to prevent the prevent to prevent the prevent to prevent the prevent to prevent the prevent to prevent to prevent the prevent to prevent	pudding to the resident as he mpts and encouragement to ation as would swish it around resident was observed to take independently but other than e medications were mixed in, ten any of his meal nor offered sident continued to drink his y but would not attempt to eat .m., NA-K sat next to R48 and nt with eating his fruit, the ly consumed all of his fluids at epted the offered food and ate of his fruit. At 6:40 p.m., he table and heated up R48's ave then set it on the table in did not offer to assist R48 .l nor offer more fluids to the .m., R48 picked up his fork bes on it, raised it slightly, then the plate; R48 was not y of his food other than the fruit		DEFICIENC		

STATEMEN	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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		00085	B. WING		08/	10/2018
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLET DATE
2 800	Continued From pa	age 42	2 800			
	LPN-A was also ad R48 at that time. L medications in pud a drink. R48 obser in his mouth. Whe LPN-A instructed N more at that time a didn't want the resi R48 was observed his supplement into to administer media were assisting othe LPN-A approached supplement from th assist the resident resident a drink of accepted. LPN-A p the juice rather tha mouth. LPN-A the continued to set-up At 10:26 a.m., R48 in his oatmeal; the has food/fluid conte spit some of it out a with his fingers. At the dining room an they were going to observed to take di during the activity b himself. At 10:49 a replace NA-H on th approached R48 at hands. NA-E aske finished eating and NA-E also asked R juice and the reside When interviewed a that sometimes R4	to assist another resident; Iministering medications to .PN-A administered R48's Iding then offered the resident rved to swish the fluid around in NA-D returned to assist R48 IA-D to not attempt to feed R48 is he wasn't swallowing and dent to choke. At 10:17 a.m., to place his glass containing this oatmeal; LPN-A continued cations and NA-D and NA-H er residents. At 10:21, a.m., I R48, removed his glass of ne oatmeal, and attempted to with eating. LPN-A offered the orange juice which he prompted R48 to try to swallow n swishing it around in his n washed his hands and to and administer medications. was observed with his fingers resident continued to swish ents in his mouth. R48 would at times then wiped his mouth t 10:34 a.m., the pastor entered d greeted the residents stating have hymn sing. R48 was rinks of his Kemps supplement out did not attempt to feed a.m., NA-E (who had come to ne unit at 10:00 a.m.), nd cleaned the oatmeal off his ent indicated that he did. at that time, NA-E confirmed -8 was able to eat sometimes required				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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		00085	B. WING	B. WING		C 08/10/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY						
(X4) ID	SUMMARY STA		M, MN 56101	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLET DATE	
2 800	Continued From pa	ige 43	2 800				
	assistance.						
	confirmed R48 required R48 required R48 required refuse to eat. RN-0 resistive to assistant would stop and the subsequent intervied RN-C stated the state of people to feed and	on 8/9/18, at 10:59 a.m. RN-C uired extensive assistance of s though sometimes he did C stated if the resident was nce would expect that staff n reapproach. On ew on 8/10/18, at 2:41 p.m. aff on Heritage Court had a lot nd not enough help. DRE INFORMATION					
	Restorative Nursing:						
	R48 and R39 did no services per the pla	ot receive restorative nursing an of care.					
	the resident had a lintervention due to related to dementia freezing gait and pl plan interventions of	st revised 7/24/18, indicated need for restorative limited physical mobility a, Parkinsonism evidenced by hysical weakness. The care directed nursing rehab staff to sive range of motion and a 3 times a week.					
	dated May 2018-Au restorative nursing the following: May opportunities (5/18/ of 21 opportunities July 3018 - 2 times	boumentation Survey Reports ugust 2018 related to rehab completion indicated 2018 - one time out of 23 (18). June 2018 - 3 times out (6/8/18, 6/14/18, 6/19/18). out of 21 opportunities August 2018 - 1 out of 8 8).					
		on 8/9/18, at 1:11 p.m. NA-E Illed from restorative to work					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING	B. WING		C 08/10/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
		705 SIXT	H STREET				
OOD S	AMARITAN SOCIETY	- WINDOM WINDON	I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 800	Continued From pa	age 44	2 800				
		e called in. NA-E further ulled from restorative that day.					
	confirmed being pu services to the Her calling in. When a duties he was sche	on 8/9/18, at 2:08 p.m. LPN-A ulled from restorative nursing itage Court unit due to a staff sked if the restorative nursing eduled to complete would be er staff in his absence LPN-A ow.					
	physical therapist (the majority of the therapy and NA-E stated when a resid therapy a restorativ PT-H confirmed it v	on 8/10/18, at 03:07 p.m. the PT)-H stated LPN-A completed restorative nursing rehab also had been trained. PT-H dent was discharged from /e plan was then put into place was nursing's responsibility to ive plan was put into place and fied nursing staff.					
	director of nursing services (HR) direct DON stated the rest scheduled with the the monthly schedu try to have a least of scheduled daily Mo confirmed sometim staff to work on the having concerns by restorative plans no confirmed not track services were getti	on 8/10/18, at 3:25 p.m. the (DON) stated the human ctor was in charge of staffing. storative nursing staff is day sheet and included into ule. DON further stated they one restorative nursing staff onday through Friday. DON hes they had to pull restorative e floor. DON further stated not rought to her related to ot getting completed. DON king if the restorative nursing ng completed. DON reviewed lan and was surprised that					
	there were so man therapy. DON con	y "holes" in the completion of firmed she had not been told staff that programming was not					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		A.		A. BUILDING:		С	
		00085	B. WING			10/2018	
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET , MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	ige 45	2 800				
	she stated, I suppo week. I get arm ar step. I am suppose band hand too. Sh it at all in August ye R39 took me to her spread sheet she h documented on the she received restor and 31. She state on June 30 and sin really bad. She stated out a supposed to be doi good. She stated very good but I hav stated I am suppose Wednesday and Fr a.m. R39 was obse aide performing res looked at surveyor, shoulders and smile R39 was asked if s laughed and pointe back of her door ar will tell you. Staff ha 17 and 18th that re- that's how much I walk 1-2 time a day all. They just didn't When asked if she stated I was able to can. I haven't done R39's care plan, las resident had a need due to limited physi	e spread sheet the days in July ative. The days were 2, 5, 24 d a staff member had retired ce this occurred it has been ated one of the nurses was ng it and the nurse is not very there is one other girl who is en't seen her in awhile. She ed to get it Monday, iday. On 8/7/18, at 11:30 erved in the therapy room with storative exercises. R39 shook her head, shrugged her ed. On 8/9/18, at 2:05 p.m. he got walked by staff. She d to a June calendar on the nd stated well look at that, that ad initialed on June 13, 14, 15, sdient was walked. She said got walked. I was supposed to v. Now they don't walk me at c and I don't know why. was able to walk now she o before but don't know if I still					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ	E SURVEY PLETED	
		00085	B. WING			C 08/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 800	Goal: resident will r mobility of transfer using handrail. Inter range of motion (R with red T-band, 20 times per week, ac left seated exercises times per week, ac exercises with 0# v week, active ROM times per week, par reps as tolerated 3 plan updated 8/2/19 unable to ambulate using a total lift for Review of R39's nu why resident was m per the care plan. surveyor identified changes in residen able to ambulate of restorative program order for skilled the be obtained to set of restorative program about her abilities to her. Review of R39's D dated June 2018-A restorative nursing the following: Wal 2018, 2 times (5//1 (6/4, 6/5, 6/11, 6/1 2018, 2 times (7/3)	dently transfer and ambulate. maintain current level of ring independently in bathroom erventions included active OM) upper extremity (U/E) left 0 repetitions (reps) times 2, 3 tive ROM lower extremity (L/E) es with 3# weight 20 reps 3 tive ROM L/E right seated veights 10 reps 3 times per NuStep at level 5 10 min 3 assive ROM to right arm 20 times per week. The care 8, also indicated R39 was e or transfer independently transfers. ursing notes does not indicate not walked or had restorative A note written 8/8/18, (after issue) identified that due to at condition she is no longer r use the NuStep as part of her n. Once she has stabilized an erapy to evaluate and treat will up further orders for her n. Resident is not realistic but this has been explained to Documentation Survey Reports august 2018 related to rehab completion indicated lking 1-2 times per day: May 10, 5/29) June 2018, 7 times, 5, 6/18, 6/19 and 6/28). July 3, 7/9). 20 days were marked	t)	DEFICIENCY			
innesota D	the following: Wal 2018, 2 times (5//1 (6/4, 6/5, 6/11, 6/1 2018, 2 times (7/3 not applicable. Aug applicable rest x' d	lking 1-2 times per day: May 10, 5/29) June 2018, 7 times, 5, 6/18, 6/19 and 6/28). July					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00085	B. WING			C 08/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	′ - WINDOM	TH STREET M, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 47	2 800				
	August times 2 (8/	/7, 8/8).					
	When interviewed on 8/8/18, at 8:00 a.m. physical therapy aide (PTA)-A stated I know that restorative is short so I don't know how much is getting done I think nursing is doing it if they don't have aides						
	confirmed being put the floor if someon confirmed being put She stated she get and the NuStep. So doing it if she refus me. You have to tr because she alway from 9:15 to 9:30 it M-Tu-Th if I don't g	on 8/9/18, at 1:11 p.m. NA-E ulled from restorative to work e called in. NA-E further ulled from restorative that day. is upper and lower exercises She stated it depends on who is ses. She has never refused for ry to get her before bible study /s goes to that if you get her it's fine. She stated I see her get pulled to the floor. We had the end of June so it doesn't	r				
	confirmed being pu services to the Her calling in. When a duties he was sche	on 8/9/18, at 2:08 p.m. LPN-A ulled from restorative nursing itage Court unit due to a staff sked if the restorative nursing eduled to complete would be er staff in his absence LPN-A ow.					
	nursing assistant (l 2 assist 20-30 feet	on 08/10/18, at 12:14 p.m. NA)-L stated R39 walked with . She stated it's been a nk. The aides do the walking ve.					
	physical therapist (the majority of the	on 8/10/18, at 03:07 p.m. the PT)-H stated LPN-A completed restorative nursing rehab also had been trained. PT-H	d				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00085	B. WING		C 08/10/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET , MN 56101			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET
2 800	Continued From pa	age 48	2 800			
	therapy a restorative PT-H confirmed it wassure the restorative completed by quali R39 had a program transferred to restor March she was on her off in March she goals and was inder not meet independe When interviewed of director of nursing services (HR) director DON stated the rest scheduled with the the monthly schedu try to have a least of scheduled daily Mot confirmed sometime staff to work on the having concerns br restorative plans not confirmed not track services were gettil R48's restorative p there were so many therapy. DON configured by the restorative s getting done. The I not be documenting restorative sheets. available. She statt wasn't walked in Ju with a change in co-	on 8/10/18, at 3:25 p.m. the (DON) stated the human stor was in charge of staffing. storative nursing staff is day sheet and included into ule. DON further stated they one restorative nursing staff onday through Friday. DON hes they had to pull restorative a floor. DON further stated not rought to her related to of getting completed. DON king if the restorative nursing ng completed. DON reviewed lan and was surprised that y "holes" in the completion of firmed she had not been told taff that programming was not DON also stated staff should g not applicable on the It should be refused or not red I don't know why she uly. She stated she just started prodition this week. I don't know it in June. We had someone so that could be why it didn't				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		A. D		A. BUILDING:		С	
		00085	B. WING		08/	10/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		TH STREET 1, MN 56101				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 800	Continued From pa	age 49	2 800				
	SEE F676 FOR AD	DITIONAL INFORMATION					
	RESIDENT/FAMIL' OF STAFFING	Y CONCERNS WITH LACK					
	R48 had severe co required extensive ADLs. When interv family member (FM a while for R48 to g staff had told her h prior to being incon feeling R48's mout	PS dated 6/29/18, identified gnitive impairment and assistance to complete his viewed on 8/6/18, at 4:07 p.m. 4)-G stated sometimes it takes get help to get to the bathroom e usually gets there on time stinent. FM-G further stated h had seemed quite dirty at ed if staff brushed his teeth.	S				
	Brief Interview for N 15 indicating intact indicated R39 requ toileting. When inte 8/7/18, at 9:15 a.m were short of help. working but a lot of wait. R39 further s	S dated 6/15/18, identified a Mental Status (BIMS) score of cognition. The MDS further ired extensive assistance with erviewed on . R39 stated last night they . They have to have 4 (NAs) times they don't; we have to stated having to wait an hour en incontinent due to waiting					
	indicated R16 had Status score (BIMS cognition. The MDS supervision with on for transfers and w physical assistanc hallway and toiletin 8/6/18, at 6:44 p.m bed pan at night be use those machine	OS assessment dated 5/18/18, a Brief Interview for Mental S) of 15 indicating intact S also identified R16 needed ie person physical assistance alking in room and limited e of one with walking in g. When interviewed on . R16 stated having to use the ecause it takes two people to is (lifts) and I had to use the ther stated the bed pan would					

		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00085	B. WING		08/	10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		TH STREET M, MN 56101			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET
2 800	Continued From pa	age 50	2 800			
		would end up with a wet id there is no other way you with it.				
	BIMS score of 8 ind impairment. The M resident required e transfer and toilet u 8/6/18, at 4:01 p.m to an hour for assis further stated havin	IDS dated 7/9/18, identified a dicating moderate cognitive MDS further indicated the xtensive assistance with use. When interviewed on . R58 stated having to wait up stance with toileting. R58 ng had accidents in my pants, ast night. I was laying in poop s."				
	STAFF CONCERN	IS WITH LACK OF STAFFING	i			
	medication aide (T staffed Heritage Co NAs. TMA-A state resident to staff rat the resident's sund stated she had wor	on 8/6/18, at 2:34 p.m.trained MA)-A stated they usually burt with 1 nurse or TMA and 2 d that was usually a good io though in the evening when lown it can get really wild. TM/ rked an evening shift last week d she had 2 NA's on as it k out that way.	4			
	stated she was sup a.m. this morning a leave. NA-H stated that stays and help had to leave for he ran behind today. N could use more he further stated feelin a staff person in the most residents gat	on 8/9/18, at 10:29 a.m. NA-H posed to be done at 10:00 and is just getting ready to d they usually have a night aide s them get people up but she r other job at 6:30 a.m. so they NA-H stated sometimes they Ip in Heritage Court. NA-H ng that there should always be e main dining room area where her when out of their rooms; 't possible when the staff need	e /			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00085	B. WING		C 08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
2000 8	AMARITAN SOCIETY	705 SIX1	H STREET			
3000 3	AMANITAN SOCIETT	WINDOM	I, MN 56101			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 51	2 800			
	then stated, "Yes, v	ve could use more help."				
	When interviewed of confirmed R48 required one staff with meal refuse to eat. RN-0 resistive to assistant would stop and the subsequent interviewed RN-C stated the state of people to feed and When interviewed of indicated Heritage from any other part staffing. LPN-A state building and also w LPN-A further state restorative today to nurse scheduled can when working the of TMA or LPN sched the residents their I confirmed this did p behind. LPN-A furth on other units are r breakfast meal. W services he was to were still being con- know.	led assistance with eating. on 8/9/18, at 10:59 a.m. RN-C uired extensive assistance of s though sometimes he did C stated if the resident was nee would expect that staff n reapproach. On ew on 8/10/18, at 2:41 p.m. aff on Heritage Court had a lot nd not enough help. on 8/9/18, at 2:08 p.m. LPN-A Court was really no different t of the building as far as ated he floats all over the rorks in restorative therapy. ed he was pulled from o work in Heritage Court as the alled in. LPN-A confirmed that day shift on Heritage Court, the uled is responsible for serving breakfast and further out his medication pass ther confirmed nurses/TMAs not responsible for serving the hen asked if the restorative provide that day for residents npleted, LPN-A stated he didn'				
	states sometimes to Court but not alway how the residents we and behaviors. NA was supposed to so	on 8/9/18, at 2:13 p.m. NA-D hey have enough in Heritage /s; a lot of it depended upon were doing related to health A-D stated the night staff NA tay until 7:30 a.m. to help get at doesn't always happen.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00085	B. WING			C 08/10/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET				
		WINDOM	, MN 56101			1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 800	Continued From pa	age 52	2 800				
	schedule those em stated today they d and it was really dif fed as the other NA and was giving bat of the residents are wait to get assistan When interviewed stated it depended could be very over NA-I stated she us that shift was the w 4:30 p.m. as they w staff during that tim day shift it's very bu resident's up in the staff will stay until 7 always. NA-I state unit would definitely try to always have a that is where the m when awake; occas	until 7:30 a.m. so they only ployees until 6 a.m. NA-D idn't have a night person stay fficult to get every one up and A who worked until 10:00 a.m. hs. NA-D further stated many e 2 person assist so she had to nee with those residents. on 8/10/18, at 10:36 a.m. NA-I upon the day but at times it whelming in Heritage Court. ually worked evenings and felt vorst, especially from 3:00 - vere many times down to 2 he. NA-I further stated on the usy when they are getting morning; usually a night shift 7:30 a.m. to help but not d having one more staff on the y help. NA-I also stated they a staff in the dining area as najority of the residents gather sionally they would leave the present but it's a very short					
	director of nursing services (HR) direct DON stated the rest scheduled with the the monthly schedu try to have a least of scheduled daily Mo confirmed sometime staff to work on the	on 8/10/18, at 3:25 p.m. the (DON) stated the human ctor was in charge of staffing. storative nursing staff is day sheet and included into ule. DON further stated they one restorative nursing staff onday through Friday. DON thes they had to pull restorative e floor. DON further stated not rought to her related to					
	restorative plans no	ot getting completed. DON					
	confirmed not track	king if the restorative nursing					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE			
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2 800	Continued From pa	ge 53	2 800				
	R48's restorative pl there were so many therapy. DON conf by the restorative s getting done.	ng completed. DON reviewed an and was surprised that y "holes" in the completion of irmed she had not been told taff that programming was not					
	During interview on 8/10/18, at 3:34 p.m. the human resources (HR) director stated they had an acuity rate which determines the staffing on each unit.						
	administrator stated number of residents was disbursed was residents per statio Court- 2 day NAs a Evening the same a scheduled at night 4 day NAs, 1 nurse and Heritage Court Evenings - 4 NAs a South: Days - 4 NA manager. Evenings - 1 NA and 1 nurse. The HR director co got pulled a lot to th	on 8/10/18, at 3:42 p.m. the d the acuity of staff is based or s in the building; where staff based on the acuity of the n. Ideal staffing: Heritage nd one nurse or TMA. and nights 1 NA (RN or LPN covers the building). Center - , 1 case manager for Center (400 and 500 wings), nd a nurse. Nights- 2 NAs. As, 1 nurse and case s - 4 NA's and 1 nurse. Nights infirmed the restorative aide he floor, to complete patient g restorative nursing tasks.					
	The administrator, ensure that adequa developed for suffic resident population adequate and timel bathing, repositioni eating assistance. on these policies ar	HOD OF CORRECTION: DON or designee could the policy and programs are sight staffing based on the so residents received safe, y assistance with toileting, ng, pressure ulcer care, and The facility could educate staff and perform routine evaluations ensure residents are receiving					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00085	B. WING		08/10/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE			
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2 800	Continued From pa	ae 54	2 800				
	care and services f facility could report the quality assuran	or adequate staffing. The the findings of these audits to ce performance improvement for further recommendations to					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 830	MN Rule 4658.0520 Proper Nursing Car) Subp. 1 Adequate and re; General	2 830		9/19/18		
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.					
	by: Based on observati review, the facility f services in a timely management was r (R16) who sustaine suffered harm, seve and was subsequent ankle; The facility a	ent is not met as evidenced on, interview and document ailed to provide care and manner to ensure pain naintained for 1 of 3 residents of an injury from a fall. R16 ere pain following the injury ntly diagnosed with a fractured lso failed to ensure hospice dinated for 1 of 1 (R41)		Corrected			
TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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2 830	Continued From pa	age 55	2 830				
		or edema (fluid retention) for 1 eviewed for edema in					
	Findings include:						
	R16 was admitted	ecord face sheet identified to the facility with diagnoses ed convulsions, muscle story of falling.					
	assessment dated Brief Interview for M 15 indicating intact identified R16 need person physical ass walking in room an of one with walking	nimum Data Set (MDS) 5/18/18, indicated R16 had a Mental Status score (BIMS) of cognition. The MDS also ded supervision with one sistance for transfers and d limited physical assistance in hallway and toileting. R16 aving no pain and no falls nent 2/23/18.					
	identified R16 had a R/T (related to) urin weakness evidence goal was identified activities without fu included monitor/do needed) times 72 h for s/s (signs/symp monitor for significa positioning device, lower extremity join problem dated 6/20	plan, last revised 6/18/18, an actual fall with minor injury hary tract infection (UTI) with ed by 2 falls on 6/16/18. The as resident will resume usual rther incident. Interventions boument/report PRN (as hours to health care provider toms) pain, bruises and ant changes in gait, mobility, standing/sitting balance and ht function. A care plan D/18, identified the resident had ort R/T right ankle fracture with					
		dated 6/16/18, at 5:40 a.m. gone into R16's room when					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
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2 830	Continued From pa	ge 56	2 830			
	a.m. as was her us sitting on the floor r frame with her walk Report indicated R ⁺ know what had hap the left foot being te significant swelling R16 was not able to assessing the ankle bruising, and she w back and forth, and Review of an Incide 7:25 a.m. indicated bathroom by staff. wheeled R16 into th used the grab bar t indicated staff had of the room so they resident however, F the floor. The repor the fall may have be hurting from a fall 2 R16 was assisted w staff into bed. At the bed, her pain rating 1-10 with 10 indicat Nursing notes indic specimen obtained a.m. on 6/16/18 du smelling urine. Additional notes indic 6/16/18, R16 requir the left ankle, which	t put on her call light by 5:30 ual routine. R16 was found next to the bathroom door ter next to her. The Incident 16 had reported she didn't opened, but had complained of ender to touch, but having no compared to the other ankle. b bear any weight after e however, there was no vas able to move the ankle I up and down. ent Report dated 6/16/18, at R16 had been assist to the The report indicated staff had ne bathroom and R16 had o stand up. The report then moved the wheelchair our 'd have room to help the R16 had suddenly slipped to t identified the root cause of een related to R16's left foot t hours prior. Following the fall, with the mechanical lift and 2 e time she was transferred to y was identified as a 2 (scale of ting the worst pain). ated R16 had a urine per physician order at 7:36 e to cloudy, amber and foul dicated at 7:48 a.m. on red an ice pack for swelling to n would be provided every 4 PRN), and the notes indicated	t			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
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3000 5	AMARITAN SOCIETY	- WINDOM WINDOM	I, MN 56101			
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2 830	Continued From pa	age 57	2 830			
	A nurse's note from 8:09 a.m. 6/16/18, reiterated R16 had fallen twice within 2 hours. R16 was described in the note as "Alert but confused" and had stated, "I laid there since 10 p.m. last night". The nurse's note further indicated the resident was confused because R16 had been observed in her bed at 3:30 a.m. during rounds, and there had been no calling out or screams from her during the night. The nurse documented it was unlikely R16 could have been on the floor all night: "No tears, flat affect, and skin had no reddened areas of pressureLeft ankle was still painful after administration of PRN Tylenol 650 mg (milligrams). Called primary doctor since she is confused, urine is very foul and incontinent of urine times 2 in last two hours. Used mechanical lift both times to lift her off the floor. Resident stood up in bathroom, hung onto grab bars until writer could remove the wheelchair to assist her to pivot onto toilet. That sudden, she went down slowly on her buttocks."					
	a second fall in 2 h doctor to inform R1	6/18, 8:13 a.m. indicated after ours, staff had phoned the 6 had fallen twice, hurt her left welling after 2 hours of initial				
	ankle every 4 hours ankle for swelling F	Ice pack for swelling to left s as needed. Apply to left PRN (as needed) effective not swollen but still				
	weight on left ankle stand times two as Left ankle not swol pack to affected ar	. Due to not able to bear full e after her fall, now using sit to sist to use bedside commode. len but is painful. Applied ice ea. Call placed to eLTC m care Dr. available via video)				

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2 830	Continued From pa	age 58	2 830			
	12:04 a.m. the note tablet 650 mg had note further indicate left ankle, rating it a At 12:07 a.m., the o had an ice pack pla ankle. The note inc ankle, not swollen b An eLTC (telemedie electronic signature for tylenol 325 mg 2 pain. The note incl sprained her left ar	licate with PRN Tylenol. At e indicated Acetaminophen been given by mouth. The ed R16 had discomfort in her a 5 out of 10 on the pain scale. documentation indicated R16 aced due to swelling of her left cluded, "Has ice pack to left out is very tender to touch." cine) note from 6/17/18, with e at 1:00 a.m., included orders 2 tablets every 4 hours PRN uded, "Pt (patient) recently ukle. She has an order fo rice, n medication. See order Tylenol order)."				
	have swelling and p throughout 6/17/18 th pain as an 8 out stated the Tylenol w p.m. on 6/17/18, R stand on my left leg with a sit to stand li her weight on the leg	ndicated R16 continued to bain in her left ankle . At 5:33 a.m., R16 described of 10. At 7:00 a.m., R16 vas "no help at all." At 4:15 16 stated, "I don't think I can g." However, when transferred ft, the resident had put most o eft leg with no facial grimacing had denied pain but stated the ore."	f			
	had complained that bruise was noted o	p.m., the notes indicated R16 at her right ankle hurt. A purple n her inner right ankle. The Il continue to monitor."				
	indicated R16 had (acetaminophen) 6 bathroom (BR), abl	6/18/18 at 2:03 a.m., received Tylenol 50 mg and "was gotten up to le to bear weight on both legs ful." Subsequently, notes				

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2 830	Continued From pa	ige 59	2 830			
	ankles at 2:12 a.m. included, "Resident and can't stand on placed in the sit to is placing most of l facial grimace or ar from the resident. inner right foot. Sh motion) with that fo standing and bearin 'It's a little sore is a					
	given. Pain scale 9 right leg and ankle 6/18/18, 7:30 a.m. severe right leg pai 6/18/18, 8:29 a.m. stated no relief from 6/18/18, 11:57 a.m. given. Resident co and ankle pain. 6/18/18, 1:36 p.m. administration was resident stated not	Acetaminophen 650 mg b. Resident stated no relief to pain. Resident complained of n, requesting analgesics. Pain scale 10. Resident n pain. Acetaminophen 650 mg mplained of severe right leg Acetaminophen 650 mg PRN ineffective. Pain scale 10 having any relief.				
	6/18/18, 11:06 p.m. followup. Ineffectiv badly. 6/19/18, 12:03 a.m. right foot which now the ankle and top o two days. Rather th bed pan tonight. W 6/19/18, 5:09 a.m. to void tonight since in both feet. Now to assist to raise up of	Acetaminophen 650 mg e pain scale 5 still hurting . Very painful when assessing v, is bruised entirely around f foot is swollen more than last han bear weight on it, will use /ill get X-ray tomorrow. Has been using the bed pan e she is having so much pain otal lift of mechanical lift with 2 ff the bed to change soiled I not turn, insists she's in too	t			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00085	A. BUILDING: _	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED	
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2 830	Continued From pa	ge 60	2 830				
	(Acetaminophen) 6 6/19/18, 5:10 a.m. I resident needs to b mechanical lift. Not left breast. 6/19/18, 6:39 a.m. I assist out of bed wi swollen +2 and bru when transferred fr 6/19/18, 6:39 a.m. ineffective. Pain so rate pain severe. On 6/19/18 at 9:17 facsimile (fax) to th whether R16 should foot related to swel following her falls o physician's faxed re get an X-ray of R16 was called and upd had been schedule 6/20/19, 7:01 a.m. given. Resident co pain. 6/20/19, 8:43 a.m. Administration was Resident stated hav 6/20/18, 12:25 p.m. right ankle x-ray. F 6/20/18, 4:01 p.m. facility around 3:30 Pain was rated at 5 6/21/18, 6:17 a.m. not effective. Pain	. Resident left at 10:45 to get Resident left in wheelchair. Acetaminophen 650 mg given. ed of moderate pain in right analgesics. Resdient arrived back at p.m. Right ankle was splinted. Acetaminophen 650 mg was					

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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2 830	Continued From pa	age 61	2 830				
	she had right ankle in a wheelchair. Ri wrapped with ace. medicate when me An order from eLTC identified nurse cal for pain. Patient re had an order for ice medication. At this two tablets every 4 The record further to the MD on 6/16/1 had been found on bathroom with a 4 v indicated R16's RC ankle was painful w but there was no sv "Does not want to s bruising." A return f received 6/18/18, a comment, "I was ca now well. Yes?" No	Returned from hospital where e repair about 6:30 p.m. She is ight foot is splinted and Rates pain at 8 of 10. Will ds arrive. C dated 6/17/18, at 1:00 a.m. led requesting order for Tylence ecently sprained her left ankle, e but no order for pain a time Acetaminophen 325 mg hours PRN pain was ordered. indicated a fax had been sent 18, at 5:40 a.m. identifying R16 the floor after walking to the wheeled walker. The fax DM (range of motion) to left when putting pressure on foot, welling. The fax included, stand on left ankle. No fax from the physician was at 12:20 p.m. with physician alled about this, I assume all is p reply was sent to the g pain and swelling of right	5				
	indicated R16 had diagnosis or condit non-pharmacologic and rest. The asse	cal interventions to include: ice ssment also identified the regimen of PRN Tylenol 650					
	6/20/18 indicated: distal fibular fractur	gs of the right ankle dated "Findings: " a Weber type B re. Probable medial malleolar or osteopenia no acute					

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2 830	Continued From pa	age 62	2 830			
	displaced facture is seen in teh mid to forefoot. of the right ankle."					
	(DON) on 8/9/18, a should have been in more timely way ra- verified no follow u medication was eff the resident's pain ability due to the pa- complaints of pain since there was sw the DON confirmed her room with walk the falls required tr mechanical lift and said the doctor sho fax had been recie R16's increased pa- condition. The DOI called the physician instead of faxing on to get the resident stated they saw bru- left then on the righ addressed and add E-kit (emergency k make her more con obviously not worki	th the director of nursing at 10:24 a.m. she stated staff in touch with the doctor in a ther than faxing. The DON p was done to ensure the pain ective, or to notify the doctor of status and change in ADL ain. The DON stated with something obviously changed velling and bruising. In addition, d R16 had been independent in ing prior to the falls but after ansfer assistance with a 2 assist. As such, the DON buld have been notified after his ved 6/18/18 to notify him of ain, swelling and change in N stated the nurse should have n about getting an X-ray n 6/19, and should have tried in for the X-ray sooner. She uising on the 17th, first on the nt which should have been ded, "we have pain meds in the it, we could have used to mfortable since the Tylenol was ing for pain control."	5			
	of the increased pa He stated although fall the morning it h fax until Monday m he'd responded ba	d he should have been notified ain and swelling of the ankle. he was notified by fax of the happened, he did not see the horning 6/18/18 at which time ck and asked if everything was				
nanata Di		did not hear anything back y asked for an X-ray on the				

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2 830	Continued From pa	age 63	2 830			
	19th."					
	COORDINATION (OF HOSPICE SERVICES:				
	The facility failed to for R41.	o coordinate hospice services				
	6/7/18. The form in originally been initia	ctor had signed a ication of hospice services on ndicated hospice services had ated 3/18/18, due to R41's degeneration of the brain.				
	indicated R41 had and total dependent	nange MDS dated 3/23/18, severely impaired cognition, nce with all activities of daily MDS also indicated R41 was services.				
	a terminal prognosi dementia and was Interventions includ coping skills, conta	vised 4/3/18, indicated R41 had is related to end stage receiving hospice care. ded: assess resident and family ct hospice staff for support as nursing staff to provide for the resident.				
	observed at the nur papers was a pape FACILITY STAFF! (name of hospice).	umerous papers attached was rses station. Under numerous r that said ATTENTION "[R41] is under the care of " The team was identified as er and chaplain. No aide or				
	volunteer was ident located on the clip of hospice) nurse-v provides AM (morn	tified. A second page was board under that page: "(name veekly visits on Monday, Aide- ing) ADL cares Monday thru S (social service) Thurs/Fri				
	(Thursday/Friday).	No patient name was identified e. The hospice agency plan of				

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2 830	Continued From pa	age 64	2 830				
	care provided by the facility also failied to include a hospice visit schedule on it.						
	hospice aide was p 7:43 a.m. R41 was being fed by a facil	on 8/8/18, at 7:05 a.m. a present giving R41 a bath. At sitting at the breakfast table ity staff member. The staff aide left after giving R41 her					
	assistant (NA)-D st [hospice staff] are of For instance, today because they had t Sometimes they give sometimes they just We don't know day either. Sometimes don't. I think they a week or something two. We never known a.m. when they are	a 8/8/18, at 8:13 a.m. nursing (ated, "we don't know what they going to do when they come. If they couldn't feed her to go do something else. We her a bath and feed her, st feed her. We never know. They tell us, sometimes they re supposed to come 3 days a but they maybe only come w what time, sometimes it's 6 e supposed to be her at 8. e come at like 4 in the					
	stated, "you never l will come. Sometir have to leave beca somewhere else so	a 8/8/18, at 8:30 a.m. NA-F know around here when they nes they come and then they use they have to go they don't do everything they they can't make it they don't ne another day."					
	stated, "There is a comes every morni between 6 and 8 a. a social worker tha	n 8/8/18, at 9:00 a.m. RN-C calendar at the desk. The aide ing Monday through Friday .m. They have a chaplain and t come in the later part of the omes on Tuesday, she was					

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2 830	here yesterday. She comes a lot. If they they just come and are stable so I'm nd do let the nurse knd aides should be told During interview on practical nurse (LP where the calendar order to know wher came onto the unit stated, "The calend During observation hospice aide (HA)-, room feeding R41. are here 5 days per 5:30 a.m. because also. We have 5 dif different schedules clients are, and whe they come. If I do n and if I don't do mo breakfast, play mus bath is done so the go because we we we had to split visit to the staff really ur ordinary. I just com room to help her. I something I will, su or out of the ordina During interview wit p.m. she stated, "T schedule. We need	e [R41] has a volunteer that can't make it they don't tell us ther day. My hospice people of concerned about it. If they by they aren't coming then the d that too." 8/8/18 at 9:28 a.m., licensed N)-B stated she did not know for hospice was located in n hospice was coming. RN-B during the interview and lar is under the clip board". on 8/9/18, at 7:47 a.m. a A was observed in the dining At that time, HA-A stated, "We r week for [R41]. I come at I have another patient here ferent aides and we all have . It depends on where the b has them, as to what time norning cares then I don't feed, rning care then I feed her sic, curl her hair. Normally her n I feed her. Yesterday I had to re short, someone called in so s up so I had to go. I don't talk nless something is out of the e in and go directly to her f I need to tell them [staff] ch as if something is different					

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3000 3	AMARITAN SOCIETT	WINDO	M, MN 56101			1	
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2 830	Continued From pa	age 66	2 830				
	EDEMA MONITOR	RING					
	diagnoses of edem	ort dated 8/10/18, included a, macular degeneration (an auses vision loss), and					
	assessment dated a Brief Interview of indicating a modera MDS further indica	mum Data Set (MDS) 5/4/18, identified R7 as havin Mental Status (BIMS) of "8" ately impaired cognition. The ted R7 required assistance ransfers, dressing, toilet use, ng.	g				
	required assistance (ADL's) related to in weakness, and imp	ewed 5/17/18, indicated R7 e with activity of daily living mpaired vision, muscle paired cognition. The care ankles.					
	6/12/18, included L	rent physican orders dated asix (a medication to reduce ody) 80 milligram (MG) daily fo	or				
	was observed to ha and ankles. The re- chair in her room w The resident had w socks on, however to R7's ankles from	on 8/8/18, at 12:50 p.m., R7 ave bilateral edema in her fee esident was sitting in a recline <i>i</i> th her feet resting on the floc elcro closing shoes and gripp there was visible indentation the grippy socks. The right eddened appearance.	r pr.				
	nursing assistant (I recliner chair. R7	on 8/9/18, at 8:46 a.m. NA)-C transferred R7 into a was wearing socks and shoe ateral edema to ankles was	s,				

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2 830	Continued From pa	age 67	2 830			
	noted, and her feet NA-C left the room	remained on the floor when				
	confirmed R7 had further stated there	n 8/8/18, at 10:04 a.m. NA-C edematous ankles. NA-C e were no specific interventions indicated R7 would elevate her to.				
	registered nurse (F standing edema to	n 8/8/18, at 1:09 p.m. RN)-B indicated R7 had long her lower extremities. RN-B as no formal monitoring in a.				
	2:22 p.m., R7 was her feet on the grou lower extremities s RN-C further verifie redness present bu noted from R7. RN pitting edema (swe to cause an indenta the skin when depr ankle and foot and (indentation of 2 m foot. RN-C stated support stockings i R7 should have oth	and interview on 8/9/18, at sitting in her recliner chair with und. RN-C assessed R7's tating they were cool and dry. ed right lower extremity had a ut no warmth or discomfort N-C identified R7 had two plus illing that is significant enough ation of 3-4 millimeters deep in ressed with a finger) in right one plus pitting edema illimeters) in left ankle and R7 had refused to wear n the past, however indicated her interventions in place to or the edema, confirming there is at this time.				
	director of nursing	n 8/10/18, at 2:48 p.m. the (DON) confirmed R7's lower hould be monitored with ce to control it.				
	A facility policy title indicated each resi	d Care Plan revised 11/16, dent will have an				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
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2 830	Continued From pa	ge 68	2 830				
	plan of care that wil and timetables dire maintaining the res nursing, physical, fu psychosocial and e use of departmenta Assessment Instru	on-centered, comprehensive Il include measurable goals cted toward achieving and ident's optimal medical, unctional, spiritual, emotional, ducational needs. Through al assessments, the Resident ment and review of the any problems, needs and will be addressed.					
	The director of nurs review and re-educ procedures to ensu issues are properly	THOD OF CORRECTION: sing or her designee could ate all staff on the policies and the that all resident's health monitored and provided. The or her designee could develop to ensure ongoing					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			9/19/18	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which	r				
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					
	B. a resident w	ho has pressure sores					

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			I, MN 56101	PROVIDER'S PLAN OF CORRECTIO	NI (VE)
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2 900	Continued From pa	age 69	2 900		
		y treatment and services to revent infection, and prevent veloping.			
	by: Based on observative review, the facility for assess and implement interventions for 1 of current facility acquer the factor of	ent is not met as evidenced ion, interview and document ailed to comprehensively nent pressure relieving of 1 resident (R48) with two uired stage 2 pressure ulcers. ice resulted in actual harm for ge 2 pressure ulcer worsened pressure ulcer developed.		Corrected	
	Findings include:				
F F V C	R48 had been adm with diagnoses incl	ecord Face Sheet, indicated itted to the facility on 1/5/18, uding: Parkinson's disease, illation, heart failure, pain and			
	assessment dated severe cognitive im dependent on staff and required extens mobility, transfers, personal hygiene. R48 was frequently bladder, was at risk	himum Data Set (MDS) 6/29/18, indicated R48 had apairment, was totally with locomotion on/off the unit sive assistance with bed dressing, eating, toilet use and The MDS further indicated incontinent of bowel and for pressure ulcers, and relieving device in bed and			
	included: The residule ulcer development	plan, last revised 7/24/18, dent has potential for pressure R/T (related to) needs assist equent bladder incontinence.			

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2 900	Continued From pa	age 70	2 900			
	The interventions in mattress and cush nurse immediately breakdown; redness discoloration, etc. r R48's Mobilization dated 6/28/18, indi- torso strength to m position, used a sit staff when transfer required assist of tr ambulation. The d support R48 needed bed from side-to-si sitting on the edge seated position on	ncluded: Pressure reduction ion in w/c (wheelchair). Notif of any new areas of skin ss, blisters, bruises, noted during bath or daily card Support Data Collection Tool cated the resident had enoug laintain an upright, seated -to-stand lift with assist of two ring between surfaces, and wo staff with a walker for lata did not indicate what ed to position up in bed, turn i ide, to move from lying to of bed, or to move from a the side of the bed to a lying bed. The data indicated:	y e. h o n			
	Pressure Sore Risl 13, indicating R48 breakdown. In add	aden Scale for Predicting k dated 6/28/18 was scored a was at moderate risk for skin ition, R48's recent Skin dated 8/5/18, indicated: no served.				
	7:15 a.m. until 9:38 dining area. Staff v in and out of the di breakfast during th the footrest of the v hanging down with R48 would move h make moaning/hur a.m., nursing assis and asked if he was	s continuously observed from a.m. lying in a recliner in the were assisting other residents ning room and providing tat time. R48 had one leg on recliner with the other leg one shoe off and one shoe of is legs periodically and would mming type sounds. At 9:38 stant (NA)-D approached R48 is ready to get up; the resider . NA-D and NA-F pivot to his wheelchair (w/c) which	9 5 9n.			

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2 900	Continued From pa	age 71	2 900							
		ucing waffle air cushion on the								
		's recliner did not have a								
		cushion on the seat. NA-D								
		into the tub room to assist hin	1							
	to the toilet. NA-D indicated the night aide (NA-J) had completed R48's morning cares earlier, and									
		o the toilet around 6:00 a.m.								
		2 hours earlier). NA-D and								
		ed to transfer Ŕ48 onto the								
		vas finished on the toilet, NA-D)							
		e resident up to provide								
	•	ottom was observed to have 2								
		as, one on the coccyx and one outtock near the crease; the								
		and approximately 0.5								
		diameter. When asked if the								
		A-D stated they were new to								
	her. The NAs then	sat the resident back down								
		alerted the nurse to come into								
		serve the resident's bottom.								
		nurse (LPN)-B entered the tub								
		d R48 had 2 open areas on his								
		ted the areas were new to her have to research the resident's								
		nake sure they had not been								
		. LPN-B then instructed the								
		sident breakfast first prior to								
		t or measuring the open areas								
		mmediately following the								
		confirmed R48 always slept in								
		lining area. NA-D stated when								
		me to the facility they would								
		n sleep in the recliner in his nt had slept in a recliner at								
		-D stated R48 would crawl out								
		s room and come out to the								
		g area to sleep. NA-D stated								
	per R48's preference	ce, they continued to have him								

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Continued From pa	ge 72	2 900			
stated staff try to re though sometimes stated sometimes t	position R48 every 2 hours it can be longer. NA-D further he resident was resistive to				
8/8/18, and sent at has an open area of an order to read Hy Change q (every) 5 dislodged or soiled physician, dated 8/9	11:34 a.m. indicated: "[R48] on his coccyx. May we have rdrocolloid to open area. days or when it becomes " A fax response from the 9/18 at 10:07 a.m., was				
in the recliner in the bent and eyes close time NA-D confirme transferred into the 12:50 p.m. NA-D fu not yet measured of to the open areas of	e dining room with his knees ed. When interviewed at that ed the resident had been recliner at approximately urther confirmed LPN-B had or done any type of treatment on R48's bottom as she was				
stated she had app the open area on R the dressing was la smaller superficial coccyx as well. Wh open area on R48's stated not realizing one open area. LP back to work tomor it then. LPN-B com	lied a hydrocolloid dressing to 48's coccyx. LPN-B stated reddish areas below the nen asked about the other s right upper buttock, LPN-B the resident had more than N-B then stated she would be row morning and could look at firmed she had not measured				
	PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa When interviewed of stated staff try to re though sometimes stated sometimes stated sometimes stated sometimes stated sometimes trepositioning, and of the move. A facsimile (Fax) to 8/8/18, and sent at has an open area of an order to read Hy Change q (every) 5 dislodged or soiled. physician, dated 8/8 reviewed with phys On 8/8/18, at 1:10 p in the recliner in the bent and eyes close time NA-D confirmed transferred into the 12:50 p.m. NA-D fund not yet measured of to the open areas of awaiting direction fund manager (RN)-C. When interviewed of to the open area on R the dressing was la smaller superficial for coccyx as well. We open area on R48's stated not realizing one open area. LP back to work tomor it then. LPN-B con	OF CORRECTION IDENTIFICATION NUMBER: 00085 00085 PROVIDER OR SUPPLIER STREET AL AMARITAN SOCIETY - WINDOM 705 SIXT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 72 When interviewed on 8/8/18, at 10:27 a.m. NA-D stated staff try to reposition R48 every 2 hours though sometimes it can be longer. NA-D further stated sometimes the resident was resistive to repositioning, and other days he was up and on the move. A facsimile (Fax) to R48's physician dated 8/8/18, and sent at 11:34 a.m. indicated: "[R48] has an open area on his coccyx. May we have an order to read Hydrocolloid to open area. Change q (every) 5 days or when it becomes dislodged or soiled." A fax response from the physician, dated 8/9/18 at 10:07 a.m., was reviewed with physician approval of this plan. On 8/8/18, at 1:10 p.m. R48 was observed laying in the recliner in the dining room with his knees bent and eyes closed. When interviewed at that time NA-D confirmed the resident had been transferred into the recliner at approximately 12:50 p.m. NA-D further confirmed LPN-B had not yet measured or done any type of treatment to the open areas on R48's bottom as she was awaiting direction from the registered nurse case manager (RN)-C. When interviewed on 8/8/18, at 1:57 p.m. LPN-B stated she had applied a hydrocolloid dressing to the open area on R48's coccyx. LPN-B stated the dressing was large enough to cover the smaller superficial reddish areas below the coccyx as well. When asked about the other open area on R48's right upper buttock, LPN-B stated not realizing the resident had more than one	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00085 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST AMARITAN SOCIETY - WINDOM TO5 SIXTH STREET WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 72 2 900 When interviewed on 8/8/18, at 10:27 a.m. NA-D stated staff try to reposition R48 every 2 hours though sometimes it can be longer. NA-D further stated sometimes the resident was resistive to repositioning, and other days he was up and on the move. 2 900 A facsimile (Fax) to R48's physician dated 8/8/18, and sent at 11:34 a.m. indicated: "[R48] has an open area on his coccyx. May we have an order to read Hydrocolloid to open area. Change q (every) 5 days or when it becomes dislodged or solled." A fax response from the physician, dated 8/9/18 at 10:07 a.m., was reviewed with physician approval of this plan. 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WING 08/ PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE AMARITAN SOCIETY - WINDOM TOS SIXTH STREET PROVIDER'S PLAN OF CORRECTION AND BE PROCEEDED BY FULL ID ID PROVIDER'S PLAN OF CORRECTION AND BE PROCEEDED BY FULL ID REGULATORY ON LGG DEBRY ON USE THE PROCEEDED BY FULL ID PRETK CROSS REFERENCE Continued From page 72 2 900 2 900 Continued From page 72 2 900 When interviewed on 8/8/18, at 10:27 a.m. NA-D 2 900 DEFICIENCY DEFICIENCY Continued From page 72 2 900 2 900 A facsimile (Fax) to R48's physician dated 8/8/18, and sent at 11:34 a.m. indicated: "[F48] Deficiency As an open area on his cocyx. May we have an order to read Hydrocolloid to open area. Change q (every) 5 days or when it becomes dislodged or solled." A fax response from the physician approval of this plan. 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2 900	Continued From pa	age 73	2 900			
	open area on the c cm round in diame	e treatment. LPN-B stated the occyx was approximately 0.5 ter. LPN-B confirmed R48 hac essure reducing cushion when	ł			
	observed getting R perform morning ca standing lift (a medi into his w/c. R48's waffle air cushion of the cushion; the rea- reducing cushion of propelled into the ta assisted with cares to transfer the resid movement. NA-D duoderm dressing NA-H informed her R48 with washing to day, NA-D and NA- to a standing positi peri-care. R48 holl bottom was being of observed; there wa resident's coccyx. the coccyx, an upp was new since the lower open area or white slough cover on the right upper to decreased in size, to be closed, there area next to it. NA the nurse. LPN-A	a.m. NA-H and NA-D were 48 up out of his recliner to ares. The NA's utilized a chancical lift) to transfer R48 w/c had a pressure reducing on the seat with very little air in cliner did not have a pressure in the seat. R48 was then ub room to be toileted and a. NA's utilized the standing lift dent onto the toilet, NA-H ef, which was soiled with bowel asked NA-H if there was a on the resident's bottom and there was not. After assisting up and changing clothes for the -H then raised the resident up on with the lift and provided lered out "Ow!" while his cleansed. R48's bottom was as no dressing covering the R48 had two open areas on er open area on the coccyx observation on 8/8/18. The n the coccyx was larger with ing the wound bed. The area puttock near the crease had was reddened and appeared was another small reddened 's put the call light on to alert entered the room and				
anacata D	new upper area on	n area's on R48's coccyx. The the coccyx measured 1.0 cm ne lower open area measured				

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2 900	Continued From pa	age 74	2 900			
	small reddened are though felt they we skin prep to R48's areas with a hydro finished dressing F dining room for bre When interviewed stated R48 was to just like all the othe When interviewed stated he was told that RN-C wanted R48's bottom as it an open area. LPI were no new interviewed	on 8/9/18, at 10:49 a.m. NA-E be repositioned every 2 hours er residents on the unit. on 8/9/18, at 10:55 a.m. LPN-A when coming on duty today him to take a good look at had been reported there was N-A stated other than that there rentions to inform RN-C of, or of what he'd observed, but tha				
	stated LPN-B had area on the coccys area due to the res though was able to duoderm dressing, updated R48's car was to be reposition after meals, for the afternoon, and at H that would be appr R48 allowed. RN- usually wait until R ready to get up bef further stated staff resistive, they let h they'd be implement cushion to be utiliz	on 8/9/18, at 10:59 a.m. RN-C reported R48 had an open s, was unable to measure the sident becoming uncooperative o cover the area with a RN-C stated she had e plan indicating the resident and once awake, before and a 3:00 p.m. activity in the HS (bedtime). RN-C confirmed oximately every 2 hours, as C stated in the morning staff 48 has his eyes open and is fore initiating cares. RN-C do not push it and if R48 was im sleep. RN-C also stated nting R48's pressure reducing ed when the resident was in as the w/c. RN-C stated prior				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		00085	B. WING			C 10/2018
IAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
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	SUMMARY STA		I, MN 56101	PROVIDER'S PLAN OF		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	COMPLET DATE
2 900	Continued From pa	age 75	2 900			
	utilized in R48's rec necessary as the re RN-C confirmed the should have been u night and was not s further confirmed a been applied when fallen off. RN-C sta for when the pressu deflating and/or nee LPN-A was usually worked as a restora When interviewed of confirmed R48's pr cushion was on the needed more air in nursing's responsib and make sure the LPN-A also stated w 2:30 p.m. he would down to therapy to have staff pick up a resident's recliner.	educing cushion had not been cliner as they had not thought i ecliner cushion was soft. e pressure reducing cushion utilized in R48's recliner last sure why it was not. RN-C new dressing should have R48's previous dressing had ated staff should be monitoring ure reducing air cushions were eded more air. RN-C stated the one to do this as he also ative therapy nurse. on 8/9/18, at 1:48 p.m. LPN-A essure reducing waffle air e low side and definitely it. LPN-A stated it was bility to monitor the cushions y were inflated adequately. when the next shift came on at have them take the cushion be inflated and would also an extra cushion to keep in the nd Data Collection dated	t t			
	the coccyx as mois When interviewed of 10:00 a.m. RN-C co visualized R48's op could not say for su associated or press	entified R48's open areas on ture associated wounds. on 8/10/18, at approximately onfirmed she had not yet ben areas on the coccyx and ure if they were moisture sure wounds. RN-C further ad not assessed R48's open				
	RN-C and the direc	on 8/10/18, at 10:38 a.m. stor of nursing (DON) I two stage 2 pressure ulcers				

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iood s	AMARITAN SOCIETY	- WINDOM	TH STREET A, MN 56101			
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2 900	Continued From pa	age 76	2 900			
	on his coccyx and a small 0.5 cm open area on the inner right buttock.					
		on 8/10/18, at 10:54 a.m. the				
		umentation of the process stat n a new skin issue was	Ť			
	discovered. The D	ON stated she would expect				
		N case manager right away sician of the skin issue. The				
		V case manager should				
		as soon as she could to asses	S			
		appropriate treatment and en the DON reviewed R48's				
		ort Data Collection Tool dated				
		the tool did not fully apply to				
		sleep in bed and was on his				
		me therefore should have bee				
		ferently in terms of positioning firmed a Positioning	•			
		Evaluation had not been				
		to determine an individualized				
		dule, and added when R48				
		s bed, the care plan should d, and she would have				
		re reducing cushion to be				
		her. The DON stated with				
		would need to see how well				
		t that pattern looked like and				
	0	e stated she would've started				
		d a half to 2 hours for a dule. As far as how often to				
		if the resident was sleeping				
		n if he had a good cushion and	k			
	had pressure map	ping completed by physical				
		ned that had not yet been				
		. DON confirmed staff should				
		he appropriate amount of air ir as utilizing. DON confirmed a				
		as utilizing. DON CONTINUED a				1
	KIN should have co	ompleted an assessment on				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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2 900	Continued From pa	ige 77	2 900			
	will go on the care p "k" and that will tran can see them on the communication writi well. DON stated ti utilize the cushion i implemented into the The procedure titled Ulcer Prevention an Requirements revis Residents who are themselves indepen Mobilization Suppo should be reposition care plan approach individualized reposition care plan approach individualized reposition care sidents skin over Positioning Assessin required tool that is individualized reposition pressure ulcer is id to observations bei bed and depth to be The registered nursi wound and the deg Wound RN Assessing ulcer, record the star records the location measurements and characteristics. Do Wound Data Colled	d, Skin Assessment, Pressure and Documentation sed 4/16 included: 6. unable to reposition indently, as indicated on the rt Data Collection Tool UDA, ned as often as directed by th res. Developing an sitioning schedule is required unable to position themselves trition, hydration, incontinence and observation of the r a period of time. The ment and Evaluation UDA is a used to determine an sitioning schedule. 7. If a entified, cleanse the area prio ing made to allow the wound e more accurately observed. se should record the type of ree of tissue damage on the ment UDA (i.e., for a pressure age). The licensed nurse in of the area, the	a s o e e s o r			
	form.					
	SUGGESTED MET	THOD OF CORRECTION:				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CON	E SURVEY	
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ood s	AMARITAN SOCIETY		H STREET I, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE	
2 900	Continued From pa	age 78	2 900				
	all residents at risk they are receiving t treatment/services from developing ar pressure ulcers. T designee, could co delivery of care; to services are impler pressure ulcer deve TIME PERIOD FOR	to prevent pressure ulcers nd to promote healing of he director of nursing or nduct random audits of the ensure appropriate care and mented; to reduce the risk for					
2 915	(21) days. MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			9/19/18	
	comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a ne the resident's cond part, activities of da resident's ability to: (1) bathe, dres (2) transfer ar (3) use the toi (4) eat; and (5) use speec	s given the appropriate vices to maintain or improve s of daily living unless ormal or characteristic part of lition. For purposes of this aily living includes the : ss, and groom; nd ambulate;					
	This MN Requirem by:	ent is not met as evidenced					

VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - WINDOM 705 SIXTH STREET WINDOM, MN 56101 PROVIDERS FLAN OF ORRECTION TO SUMMARY STATEMENT OF DEFICIENCES ENDINATION OF DEFICIENCES OF PTULING REGULATORY OR LSC IDENTIFYING INFORMATION PROVIDERS FLAN OF ORRECTION CONSERCETER ADDRESS, CITY, STATE, ZIP CODE 2915 Continued From page 79 Based on interview and document review the facility failed to provide residents (R48) reviewed for activities of daily living (ADL's) and 1 of 1 resident (R39) reviewed for position mobility. 2915 Corrected R48 was admitted to the facility on 1/5/18, per the Admission Record face sheet, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain, and muscle weakness. Corrected R48's quarterly Minimum Data Set (MDS) assessment dated (F29/16 indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. R48's care plan, last revised 7/24/18, indicated the resident had a need for restorative intervention due to limited physical mobility related to dementia, Parkinsonism evidenced by freezing gait and physical weakness. The care plan interventions directed nursing rehab staff to perform active/passive range of motion and a walking program 2:3 times a week. Review of R46's Documentation Survey Reports dated May 2018- OR august 2018 - 3 times out of 21 opportunities (6/8/18, 6/14/18, 6/19/18), July 3018 - 2 times out of 21 opportunities (7/27/18, 7/31/18), July 2018 - 1 out of 8 opportunities (6/8/18, 6	STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
Based on interview and document review the facility failed to provide restorative nursing services for 1 of 3 residents (R48) reviewed for activities of daily ining (ADC)s) and 1 of 1 resident (R39) reviewed for position mobility. 2 915 Corrected R48 squarterly Minimum Data Set (MDS) assessment dated 6/29/18 indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive actual position wolf the unit, and required extensive actual position and a walking program 2-3 times a week. R48's care plan, last revised 7/24/18, indicated the resident had a need for restorative interventions directed nursing rehab staff to perform active/passive range of motion and a walking program 2-3 times a week. Review of R48's Documentation Survey Reports dated May 2018 - One time out of 23 opportunities (6/8118, 6/14/18, 6/1			00085	B. WING		C 08/10/2018	
Based SAMARITAN SOCIETY - VINDOM WINDOM, MN 56101 (X4) ID PREEX TAG ISANDARY STATEMENT OF DEFICIENCIES (EACH DEPCIENCY MIST BE RECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) ID PREEX TAG PROVIDENS PLAN OF CORRECTIVE ACTION SACUED BE CROSS-REFERENCINA APPROPRIATE DEFICIENCY) 0 2 915 Continued From page 79 2 915 Corrected Corrected 3 services for 1 of 3 residents (R48) reviewed for activities of daily living (ADL's) and 1 of 1 resident (R39) reviewed for position mobility. Corrected Corrected R48 was admitted to the facility on 1/5/18, per the Admission Record face sheet, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain, and muscle weakness. R48's quarterly Minimum Data Set (MDS) assessment dated 6/29/18 indicated F48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility. transfer, creasing, eating, toilet use, and personal hygiene. R48's care plan, last revised 7/24/18, indicated the resident had a need for restorative intervention due to limited physical mobility related to dementia, Parkinsonism evidenced by freezing gait and physical weakness. The care plan interventions due to physical weakness. The care plan interventions due toll 21 opportunities (6/818/18). June 2018 - 3 times out of 21 opportunities (6/8118). June 2018 - 3 times out of 21 opportunities (6/8118). June 2018 - 1 out of 23 opportunities (6/8118). June 2018 - 1 out of 23 opportunities (6/8118). June 2018 - 1 out of 3 opportunities (6/811/18).	IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
WINDOM, MK 56101 PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REQUATORY OR ISCIDENTIFYING INFORMATION) PRETX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) 0 2915 Continued From page 79 services for 1 of 3 residents (R48) reviewed for activities of daily living (ADL's) and 1 of 1 resident (R39) reviewed for position mobility. 2 915 Corrected R48 was admitted to the facility on 1/5/18, per the Admission Record face sheet, with diagnoses including: Parkinson's disease, dementia, atrial fibriliation, heart failure, pain, and muscle weakness. FA4's quarterly Minimum Data Set (MDS) assessment dated 6/29/18 indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility. transfer, dressing, eating, toilet use, and personal hygiene. R48's care plan, last revised 7/24/18, indicated the resident had a need for restorative interventions directed nursing rehab staff to perform active/passive range of motion and a walking program 2-3 times a week. Review of R48's Documentation Survey Reports dated May 2018- August 2018 - 3 times out of 23 opportunities (6/8/18), 6/14/18, 6/19/18). July 3018 - 2 times out of 21 opportunities (7/2/18, 7/31/16). August 2018 - 1 out of 8 opportunities (8/1/18).			705 SIXT	H STREET			
EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) PRETX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE Color 2 915 Continued From page 79 2 915 Based on interview and document review the facility failed to provide restorative nursing services for 1 of 3 residents (R49) reviewed for activities of daily living (ADL's) and 1 of 1 resident (R39) reviewed for position mobility. Corrected R48 was admitted to the facility on 1/5/18, per the Admission Record face sheet, with diagnoses including: Parkinson's disease, dementia, atrial fibrillation, heart failure, pain, and muscle weakness. F48's quarterly Minimum Data Set (MDS) assessment dated 6/29/18 indicated R48 had severe cognitive impairment, was totally dependent on staff with locomotion on/off the unit, and required extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. F48's care plan, last revised 7/24/18, indicated the resident had a need for restorative intervention due to limited physical mobility related to demention. Parkinsonime evidenced by freezing gait and physical weakness. The care plan interventions directed nursing rehab staft to perform active/passive range of motion and a walking program 2-3 times a week. Review of R48's Documentation Survey Reports dated May 2018 - 0 times out of 23 opportunities (6/18/18). June 2018 - 3 times out of 21 opportunities (6/18/18). June 2018 - 3 times out of 21 opportunities (6/17/18). August 2018 - 1 out of 8 opportunities (6/17/18). August 2018 - 1 out of 8 opportunities (6/17/18).	3000 3/	AMANTAN SOCIETT	WINDOM	I, MN 56101			
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dated May 2018-August 2018 related to restorative nursing rehab completion indicated the following: May 2018 - one time out of 23 opportunities (5/18/18). June 2018 - 3 times out of 21 opportunities (6/8/18, 6/14/18, 6/19/18). July 3018 - 2 times out of 21 opportunities (7/2/18, 7/31/18). August 2018 - 1 out of 8 opportunities (8/1/18).		the resident had a intervention due to related to dementia freezing gait and pl plan interventions of perform active/past	need for restorative limited physical mobility a, Parkinsonism evidenced by hysical weakness. The care directed nursing rehab staff to sive range of motion and a				
When interviewed on $9/0/19$, at 1.11 π m NA Γ		dated May 2018-Au restorative nursing the following: May opportunities (5/18, of 21 opportunities July 3018 - 2 times (7/2/18, 7/31/18).	ugust 2018 related to rehab completion indicated 2018 - one time out of 23 /18). June 2018 - 3 times out (6/8/18, 6/14/18, 6/19/18). out of 21 opportunities August 2018 - 1 out of 8				
When interviewed on 8/9/18, at 1:11 p.m. NA-E		When interviewed	on 8/9/18, at 1:11 p.m. NA-E				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 915	Continued From pa	age 80	2 915				
	the floor if someon	Illed from restorative to work e called in. NA-E further Illed from restorative that day.					
	confirmed being pu services to the Her calling in. When as duties he was sche	on 8/9/18, at 2:08 p.m. LPN-A illed from restorative nursing itage Court unit due to a staff sked if the restorative nursing eduled to complete would be er staff in his absence LPN-A bw.					
	physical therapist (the majority of the therapy and NA-E a stated when a resid therapy a restorativ PT-H confirmed it w	on 8/10/18, at 03:07 p.m. the PT)-H stated LPN-A complete restorative nursing rehab also had been trained. PT-H dent was discharged from ve plan was then put into place was nursing's responsibility to ive plan was put into place an fied nursing staff.					
	director of nursing services (HR) direct DON stated the rest scheduled with the the monthly schedu try to have a least of scheduled daily Mo confirmed sometim staff to work on the having concerns by restorative plans no confirmed not track services were getti	on 8/10/18, at 3:25 p.m. the (DON) stated the human stor was in charge of staffing. storative nursing staff is day sheet and included into ule. DON further stated they one restorative nursing staff onday through Friday. DON thes they had to pull restorative e floor. DON further stated not rought to her related to out getting completed. DON king if the restorative nursing ng completed. DON reviewed					
	there were so man therapy. DON con	lan and was surprised that y "holes" in the completion of firmed she had not been told taff that programming was no					

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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2 915	Continued From pa	age 81	2 915			
	getting done.					
	R39					
	R39 was admitted including: hemiple unspecified cerebra right dominant side and chronic obstrue During interview wi she stated, I'm sup week. I get arm a	tecord dated 8/10/18, identified to the facility with diagnoses gia and hemiparesis following ovascular disease affecting e, dorsalgia, muscle weakness ctive pulmonary disease. Th R39 on 8/7/18, at 9:22 a.m. posed to get rehab 3 times a nd leg exercises and do the ed to have exercises on my				
	band hand too. Sh it at all in August ye R39 took me to he spread sheet she h documented on the she received restor and 31. She state	the further stated I haven't had et. In July I had it 4 times. In computer and pulled up a mad made. She had e spread sheet the days in July rative. The days were 2, 5, 24 and a staff member had retired ince this occurred it has been				
	supposed to be do good. She stated very good but I hav stated I am suppos	ated one of the nurses was ing it and the nurse is not very there is one other girl who is ven't seen her in awhile. She sed to get it Monday, riday. On 8/7/18, at 11:30				
	aide performing res looked at surveyor shoulders and smil	erved in the therapy room with storative exercises. R39 , shook her head, shrugged he led. On 8/9/18, at 2:05 p.m. she got walked by staff. She	r			
	laughed and pointed back of her door an will tell you. Staff ha	ad initialed on June 13, 14, 15, esdient was walked. She said				
	that's how much I	got walked. I was supposed to y. Now they don't walk me at				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _				
		00085	B. WING			C 08/10/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
OOD S	AMARITAN SOCIETY	- WINDOM	H STREET I, MN 56101				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLE DATE	
2 915	Continued From pa	age 82	2 915				
	When asked if she stated I was able to	t and I don't know why. was able to walk now she b before but don't know if I still e it for a lot of days.					
	Brief Interview for N 15 indicating intact identified a function with impairment or of two persons to w room occurred only person assistance, person with transfe supervision of one	DS dated 6/15/18, identified a Mental Status (BIMS) score of cognition. The MDS also nal limitation in range of motion n one side, limited assistance valk in corridor, walking in y one or two times with two extensive assistance of one ers and bed mobility and person with locomotion on and					
	identified R39 requ person with walking	quarterly MDS dated 3/23/18, ired limited assistance of one g in room and in corridor.					
	resident had a needue to limited physical weakness and old	st revised 1/5/17, indicated the d for restorative intervention ical mobility related to CVA (cerebrovascular hemiparesis evidenced by	ž				
	inability to independ Goal: resident will r mobility of transferr using handrail. Inter range of motion (R	dently transfer and ambulate. maintain current level of ring independently in bathroom erventions included active OM) upper extremity (U/E) left					
	times per week, ac left seated exercise times per week, ac	0 repetitions (reps) times 2, 3 tive ROM lower extremity (L/E) es with 3# weight 20 reps 3 tive ROM L/E right seated					
	week, active ROM times per week, pa reps as tolerated 3	veights 10 reps 3 times per Nustep at level 5 10 min 3 Issive ROM to right arm 20 times per week. The care					
		8, also indicated R39 was or transfer independently transfers.					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00085	B. WING		C 08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 83	2 915			
	why resident was r per the care plan. surveyor identified changes in residen able to ambulate o restorative program order for skilled the be obtained to set restorative program about her abilities h her. Review of R39's D dated June 2018-A restorative nursing the following: Wal 2018, 2 times (5//- (6/4, 6/5, 6/11, 6/1 2018, 2 times (7/3 not applicable. Au applicable rest che exercises: July 4 d refusals. August t When interviewed physical therapy ai that restorative is s how much is gettin she thought nursin didn't have aides. When interviewed confirmed being pu	on 8/8/18, at 8:00 a.m. de (PTA)-A stated she is aware short staffed and did not know g done. PT-A further indicated g was completing it if they on 8/9/18, at 1:11 p.m. NA-E ulled from restorative to work				
	the floor if someon confirmed being pu She stated R39 ge the Nustep, and in	e called in. NA-E further illed from restorative that day. ts upper and lower exercises, idicated R39 had never refused r, but it depended on what stat				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	·····	COM	PLETED
		00085	B. WING	B. WING		C 10/2018
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
GOODS	MARITAN SOCIETY		TH STREET			
		WINDOW	A, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	ige 84	2 915			
	best to try approach because she alway explained she sees and Thursdays if sh	e refused. NA-E stated it is ning R39 before bible study, is goes to that. NA-E further R39 on Monday,Tuesday, ne isn't pulled to the floor, and ember had retired at the end o ways get done.				
	confirmed being pu services to the Her calling in. When as duties he was sche	on 8/9/18, at 2:08 p.m. LPN-A illed from restorative nursing itage Court unit due to a staff sked if the restorative nursing duled to complete would be r staff in his absence LPN-A ow.				
	nursing assistant (1 2 assist 20-30 feet. couple weeks, and	on 08/10/18, at 12:14 p.m. NA)-L stated R39 walked with NA-L thought it had been a indicated the nursing ralking as well as restorative.				
	physical therapist (the majority of the r therapy and NA-E a stated when a resid therapy a restorativ PT-H confirmed it v assure the restorat completed by qualit R39 had a program transferred to resto March she was on her off in March she	on 8/10/18, at 03:07 p.m. the PT)-H stated LPN-A complete restorative nursing rehab also had been trained. PT-H dent was discharged from re plan was then put into place was nursing's responsibility to ive plan was put into place and fied nursing staff. PT-H stated a while back and was rative. From January to a program. When they took e met standing and walking ependent in sit to stand. Did ent transfers.	e. d			
		on 8/10/18, at 3:25 p.m. the (DON) stated the human				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		A. BU		A. BUILDING:		C
		00085	B. WING			10/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 915	Continued From pa	age 85	2 915			
	DON stated the res scheduled with the the monthly schedu try to have a least of scheduled daily Mo confirmed sometim staff to work on the having concerns by restorative plans no confirmed not track services were getti R48's restorative p there were so man therapy. DON con by the restorative s getting done. The I not be documenting restorative sheets. available. She stat wasn't walked in Ju with a change in co why she didn't get retire end of June s get done July and <i>b</i> SUGGESTED MET The director of num- revise policies and and implementation	THOD OF CORRECTION: sing (DON) or designee could procedures for documentation n of ambulation and restorative cate staff related to the				

	T OF DEFICIENCIES OF CORRECTION	Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00085	B. WING		C 08/10/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GOOD SA	AMARITAN SOCIETY		H STREET , MN 56101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 915	Continued From pa	ge 86	2 915		
	quality assurance c	ommittee.			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920		9/19/18
c ł a	comprehensive resi home must ensure B. a resident who activities of daily livi	is unable to carry out ing receives the necessary n good nutrition, grooming,			
	by: Based on observati review, the facility fa shaving, assistance was provided for 2 of reviewed for activitie provide oral care fo	ent is not met as evidenced on, interview and document ailed to ensure nail care, with eating, and oral care of 3 residents (R4, R48) es of daily living and failed to r 1 of 2 resident (R54) , who was dependent upon with grooming.		Corrected	
	Findings include:				
	assessment dated having severely imp assessment. The M required extensive a transfers, dressing, hygiene, and exhibi	num Data Set (MDS) 7/27/18, identified R4 as paired cognition per staff MDS further identified R4 assistance with bed mobility, toilet use, bathing, personal ted physical behavioral thers and rejected care.			
	B4's care plan revie	ewed 8/7/18 indicated the			

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		08/	10/2018
		705 SIX	TH STREET	IATE, ZIF GODE		
000 5/	AMARITAN SOCIETY	WINDOM WINDOM	<i>I</i> , MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 87	2 920			
	personal hygiene.	ssistance of 1 staff with The care plan further identified e if R4 was exhibiting ares.	b			
		n on 8/6/18, at 1:56 p.m. R4 long soiled fingernails and lon hin.	g			
	7:16 a.m., R4 cont chin hair. Nursing R4's long dirty fing you'd let us trim yo pleasant and coop	n of morning cares on 8/8/18, a inued to have long nails and assistant (NA)-D looked at ernails and stated "oh I wish ur nails". Though R4 was erative with transfers, dressing was no attempt to trim nails, provide oral care.				
	was observed in th	n on 8/08/18, at 2:43 p.m. R4 le dining room feeding herself with long dirty nails and long				
	10:19 a.m., R4 cor chin hair. NA-E st mood" and it was a Though R4 was pla transfers, dressing	n of morning cares on 8/9/18, an tinued to have long nails and tated R4 was in a "wonderful a good time to complete cares. easant and cooperative with and toileting, there was no ral cares or nail care.				
	and NA-E confirme care, shaving, or n cares. NA-D furthe assistance with the	n 8/9/18, at 1:23 p.m. NA-D ed they had not offered oral ail trimming to R4 with morning er indicated R4 required ese grooming tasks and long fingernails and chin hair.	9			
		n 8/9/18, at 2:09 p.m. RN)-C confirmed R4 had long				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _		C	
		00085	B. WING	B. WING		10/2018
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ige 88	2 920			
	"goatee". RN-C inc will refuse cares, he should be offered d nails trimmed and c On 8/10/18, at 3:02 (DON) stated her e trim nails and provi breakfast. The DO gotten R4 a new ra would expect staff t tasks when she wa A facility policy titled	h hair which she described as a dicated R4 has behaviors and owever oral care and shaving laily before breakfast, and cleaned when R4 allows. P.m. director of nursing xpectation is for staff to shave de oral cares prior to N further stated she had zor about one week prior and to reapproach or complete s cooperative if refused. d Nail Care last revised 10/17 ils clean and trimmed to				
	R54					
	identified R54 as ha Mental Status (BIM impaired cognition. R54 with a diagnos one side of the bod assistance with per R54's care plan las self care performan hemiparesis and in dress, or groom. T R54 with several na Interventions incluce personal hygiene a set up twice daily. R54's ADL care are 11/7/17 indicated en needed for all ADL' During interview on	S assessment dated 7/6/18, aving a Brief Interview for S) of 10 indicating moderately The MDS further identified is of hemiplegia (paralysis of y) and required extensive sonal hygiene. t revised 7/4/18, identified a nee deficit related to left ability to independently bathe, he care plan further identified atural teeth broken off. led staff assistance with nd assist to brush teeth after ea assessment (CAA) dated xtensive to total assist was s due to hemiplegia. 8/6/18, at 7:14 p.m. family she frequently notices food				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00085	B. WING			C 10/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	-	
300D S	AMARITAN SOCIETY	- WINDOM 705 SIXT	H STREET			
		WINDON	I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ige 89	2 920			
	were being brushed On 8/8/18, at 7:38 a room in a Broda ch not been brushed. dry toothbrush was cabinet above the s On 8/8/18, at 9:43 a sleeping in his bed. observed in the sar toothbrush. On 8/8/18, at 1:19 p During interview on stated oral cares ar residents up in the confirmed she had morning stating she On 8/10/18, at 3:02 (DON) stated her e provide oral cares p A facility policy titled revised 6/14, includ unable to carry out receive necessary s nutrition, grooming hygiene. Included i 1. General Person Care of hair, hands makeup, skin , nails R48 was admitted t Admission Record including: Parkinso	a.m. R54 was sitting in his air. He indicated his teeth had An oral care basin, including a s observed in the medicine sink in R54's room. a.m. R54 was observed to be . The oral care basin was me location with a dry o.m. toothbrush remained dry. 8/8/18, at 1:31 p.m. NA-C re completed when getting morning. NA-C then not brushed R54's teeth this e had "forgot". P.m. director of nursing xpectation is for staff to ber plan of care. d Activities of Daily Living last led: Any resident who is activities of daily living will services to maintain good and personal and oral in these are the following: al, Daily Hygiene/Grooming: , face, shaving, applying	a			
		imum Data Set (MDS) 6/29/18 indicated R48 had				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		A. BUILDING		BUILDING:		С	
		00085	B. WING			08/10/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- WINDOM	TH STREET M, MN 56101				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(THE APPROPRIATE	COMPLET DATE	
2 920	Continued From pa	age 90	2 920				
	dependent on staff and required exten	pairment, was totally with locomotion on/off the unit sive assistance with bed Iressing, eating, toilet use, and					
	resident had his ow assistance of one s	ted 7/7/18, indicated the vn teeth and required extensive staff with oral cares. Oral ned BID (twice a day) as he	9				
	member (FM)-G st	on 8/6/18, at 4:17 p.m. family ated feeling R48's mouth had at times and wondered if staff					
	and NA-H were obs cares for R48. NA recliner where he s wheelchair (w/c) via propelled R48 into then transferred R4 toilet. NA-D donner resident with washi hands and fingerna obtained a clean w washed and dried I swishing his mouth NA-D asked R48 if a towel up to his m spit. NA-D doffed I toothettes to utilize provide it. NA-D an up and provided pe	a.m. nursing assistants (NA)-E served providing morning 's transferred R48 from the slept in the dining area, into his a a standing lift. NA-H then the tub room. NA-H and NA-E 48 via the standing lift onto the ed gloves and assisted the ing his face then cleaned his ails thoroughly. NA-D then ashcloth and towel and R48's underarms. R48 was a sif he had food or liquid in it he needed to spit and brough outh but the resident wouldn't her gloves and obtained for oral care but did not and NA-H then raised resident ericare; during that time)				
	room and complete after pericare was	nurse (LPN)-A entered the tub ed a treatment to R48's bottom completed. Once LPN-A tment, NA's then finished with					

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		A. BUILDING: _			C
	00085	B. WING	. WING		10/2018
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AMARITAN SOCIETY					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 91	2 920			
NA-H then brought	R48 out to the dining room for	r			
registered nurse (F related to oral care twice a day. RN-C	RN)-C stated the expectation was as the resident allowed further confirmed staff should				
7/24/18, indicated t assist of one staff w resident with a caln with adequate eatin indicated R48 holds	he resident required extensive with eating, and to provide the n, quiet setting at meal times ng time. The care plan further s liquids/food in mouth and				
observed seated in dining room table in supper meal; R48's At 6:00 p.m. nursin R48 and asked him was assisting anoth at that time. NA-G was on his plate; th wrapped up in his of At 6:05 p.m., licens approached R48 to were mixed in pudo NA-G, LPN-C even the medications in required verbal pro swallow the medicat	his wheelchair (w/c) at the n Heritage Court during the s meal was served at that time g assistant (NA)-G addressed n if he was going to eat, NA-G her resident at the same table showed R48 that his spoon he resident had his hands clothing protector at that time. Sed practical nurse (LPN)-C administer medications that ding. With assistance from itually was able to administer pudding to the resident as he mpts and encouragement to ation as would swish it around				
	PROVIDER OR SUPPLIER AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCIES REGULATORY OR L Continued From part dressing R48 and t NA-H then brought breakfast; R48 was care. When interviewed of registered nurse (F related to oral care twice a day. RN-C always try to brush toothettes. Further review of F 7/24/18, indicated t assist of one staff of resident with a calr with adequate eatir indicated R48 hold needs reminders to On 8/6/18, at 5:50 observed seated in dining room table in supper meal; R48's At 6:00 p.m. nursin R48 and asked him was assisting anoth at that time. NA-G was on his plate; th wrapped up in his of At 6:05 p.m., licens approached R48 to were mixed in pudo NA-G, LPN-C event the medications in required verbal pro- swallow the medication	OF CORRECTION IDENTIFICATION NUMBER: 00085 00085 PROVIDER OR SUPPLIER STREET A AMARITAN SOCIETY - WINDOM TOS SIXT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 91 dressing R48 and transferred him into his w/c. NA-H then brought R48 out to the dining room for breakfast; R48 was not offered/provided oral care. NA-H then brought R48 out to the dining room for breakfast; R48 was not offered/provided oral care. When interviewed on 8/9/18, at 10:59 a.m. registered nurse (RN)-C stated the expectation related to oral care was as the resident allowed twice a day. RN-C further confirmed staff should always try to brush R48's teeth rather than using toothettes. Further review of R48's care plan, last revised 7/24/18, indicated the resident required extensive assist of one staff with eating, and to provide the resident with a calm, quiet setting at meal times with adequate eating time. The care plan further indicated R48 holds liquids/food in mouth and needs reminders to swallow. On 8/6/18, at 5:50 p.m. R48 was continuously observed seated in his wheelchair (w/c) at the dining room table in Heritage Court during the supper meal; R48's meal was served at that time. At 6:00 p.m. nursing assistant (NA)-G addressed R48 and asked him if he was going to eat, NA-G was assisting another resident at the same table at that time. NA-G showed R48 that his spoon was on his plate; the resident had his hands wrapped up in his clothing protector at that time. At 6:05 p.m., licensed practical nurse (LPN)-C approached R48 to administer medicati	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 00085 (X2) MULTIPLE A. BUILDING: B. WING O0085 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST MARRITAN SOCIETY - WINDOM STREET ADDRESS, CITY, ST WINDOM, MN 56101 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 91 2 920 dressing R48 and transferred him into his w/c. NA-H then brought R48 out to the dining room for breakfast; R48 was not offered/provided oral care. ID PREFIX When interviewed on 8/9/18, at 10:59 a.m. registered nurse (RN)-C stated the expectation related to oral care was as the resident allowed twice a day. RN-C further confirmed staff should always try to brush R48's teeth rather than using toothettes. ID PREFIX Further review of R48's care plan, last revised 7/24/18, indicated the resident required extensive assist of one staff with eating, and to provide the resident with a calm, quiet setting at meal times with adequate eating time. 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WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 91 2 920 Continued From page 91 2 920 Continued From page 91 2 920 Messing R48 and transferred him into his w/c. NA-H then brought R48 do ut to the dining room for breakfast; R48 was not offered/provided oral care. 2 920 When interviewed on 8/9/18, at 10:59 a.m. registered nurse (RN)-C stated the expectation related to oral care was as the resident allowed twice a day. RN-C further confirmed staff should always try to brush R48's teeth rather than using toothettes. 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WING (B2 MULTIPLE CONSTRUCTION (B2 MULTIPLE CONSTRUCTION PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TOS SIXTH STREET (MIN) PROVIDER'S PLAN OF CORRECTION MARITAN SOCIETY - WINDOM TOS SIXTH STREET WINDOM, MN 56101 (POVIDER'S PLAN OF CORRECTION NEOULD BE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (CROSS REFERENCE) TO THE APPROPRIATE Continued From page 91 2 920 2 920 CONSTRUCTIVE ACTION NEOULD BE (CROSS REFERENCE) TO THE APPROPRIATE Continued From page 91 2 920 2 920 2 920 DEFIDIENCY Continued From page 91 2 920 2 920 FIDIENCY DEFIDIENCY Continued From page 91 2 920 2 920 FIDIENCY DEFIDIENCY Continued From page 91 2 920 2 920 FIDIENCY DEFIDIENCY Continued From page 91 2 920 2 920 FIDIENCY DEFIDIENCY Continued From page 91 2 920

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		IDENTIFICATION NOMBER.	A. BUILDING: _				
		00085 B. WING				C 08/10/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE			
iood s	AMARITAN SOCIETY		XTH STREET DM, MN 56101				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	age 92	2 920				
	assistance. The re fluids independently his food. At 6:28 p. assisted the resider resident had alread that time. R48 acc approximately 50% NA-K got up from the meal in the microws front of R48. NA-K with eating his mea resident. At 6:55 p with a bite of potato set it back down on observed to eat any he had been assist When interviewed of stated R48 usually not having any of it	atten any of his meal nor offer esident continued to drink his y but would not attempt to ea .m., NA-K sat next to R48 ar nt with eating his fruit, the ly consumed all of his fluids epted the offered food and a of his fruit. At 6:40 p.m., he table and heated up R48' ave then set it on the table in did not offer to assist R48 al nor offer more fluids to the .m., R48 picked up his fork bes on it, raised it slightly, the the plate; R48 was not y of his food other than the fr ed with. on 8/6/18, at 6:55 p.m. LPN- ate good on his own but was tonight. LPN-C stated they he resident later to see if he	at nd at tte s n en ruit				
	The director of nurs review pertinent po to grooming, audit i grooming needs are the importance of g the audit could be r	THOD OF CORRECTION: sing and/or designee could licies and procedures related resident care to ensure e met and educate staff on grooming needs. The results reported during the quarterly committee meetings.	of				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-or	ne				
21025	MN Rule 4658.061	5 Food Temperatures	21025			9/19/18	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00085	B. WING		C 08/10/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
	AMARITAN SOCIETY	705 SIX1	H STREET			
3000 5/	AMARITAN SOCIETY	- WINDOM WINDOM	I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21025	Continued From pa	age 93	21025			
	40 degrees Fahren or below, or 150 de centigrade) or abov food" means any fo and temperature co rapid and progress toxigenic microorga This MN Requirem by:	ent is not met as evidenced				
	review, the facility f were heated and se prevent potential for facility failed to ens was kept in a clean failed to ensure app were implemented contamination of du non-original contain	ion, interview and document failed to ensure meal items erved hot enough to reduce or bodborne illness. Further, the ure 1 of 1 production mixers a and sanitary manner; and propriate storage measures to prevent potential cross ried goods stored in ners. These findings had ill 78 residents residing in the of survey.		Corrected		
	Findings include:					
	was observed. Coo on the steam table population including mashed potatoes, s gravy. In addition, pureed pork chops pork chops and tac stated these items the oven and place moments prior. CK temperatures on a	a.m. the lunch meal service ok (CK)-A had several items to be served to the resident g taco meat, pork chops, sage dressing, kernel corn, tar CK-A had pureed carrots, and mechanical soft texture to meat to be served. CK-A had just been removed from d in the steam table a few -A had documented flow sheet which identified just pork chops at appropriate				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00085	B. WING		C 08/10/20	
IAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET , MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21025	demonstrate they h serving temperature foodborne illness. If meat options had b was going to check temperature upon r the kitchen. The su temperature check CK-A removed a ba a coffee cup sitting contained another t with various pens a attempt to sanitize to placing it in the prep CK-A and the surve thermometer, and C temperatures being items: Taco meat - 91 deg Pork chop - 94 F, a Sage dressing - 91 CK-A then turned to aloud, "What do yo surveyor asked CK would be to implem low, however, CK-A would be upset if th did not want to over stated he would wa food in the steam ta temperature. Appro CK-A checked the s no temperature cha the oven. CK-A did	I temperatures recorded to ad been checked for proper e to reduce the risk of CK-A verified only the two een checked and stated he the other food items eturn from being away from urveyor requested a on the prepared items, and ayonet-style thermometer from on the counter which hermometer, a scissors along nd pencils. CK-A did not the thermometer before pared food items to be served. EX-A stated aloud the following i dentified for the various food rees Fahrenheit (F), nd,	21025	DEFICIENC	ΥΥ) 	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			С
		00085	B. WING	WING		10/2018
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21025	Continued From pa	ige 95	21025			
	following temperatu steam table:	ires while they were in the				
	Taco meat - 91 F, Pork chop - 94 F, Sage dressing - 91 Corn - 97 F, Gravy - 81 F and, In addition, all of th items were <100 F.	e pureed and mechanical soft				
	unplugged the stea main dining room d	temperatures, CK-A m table and brought it to the lespite the low temperatures K-A then began to plate and n the steam table.				
	findings, and stated re-heated to ensure DM-A acknowledge become upset with added, "I know its b choose to do? The Further, DM-A state be stored in a cup of	DM)-A was alerted to these d the food should have been e a safe serving temperature. ed the residents' would likely having to wait though, and bad, but what else can I e residents will be upset." ed the thermometer should not with pencils and scissors, and sanitized before used to check				
	was conducted with RD-A expressed for when hot enough, a to understand and temperatures to se expressed if staff h thermometer function	rve at. Further, RD-A				
	The facility's Food	Thermometer policy dated				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			С
		00085 B. WING		08/10/201		
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		TH STREET M, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21025	Continued From pa	age 96	21025			
	sanitized when ren before being insert policy further indica	hermometers should be noved from the casing, and ed into food and/or fluids. The ated a water-and-detergent used to sanitize and remove				
	dated 7/2018, iden temperature" was i listed, "cold food < food >135 degrees directed food shou cooled to ensure p	Temperature Monitoring policy tified a "Proper holding required for food safety and 41 degrees Fahrenheit, hot 5 Fahrenheit." The policy Id be cooked, reheated or roper holding temperatures service, and listed a procedure following steps:				
	the "cook-to" and " Time/temperature	ice, the cook/designee takes serve" temperatures of "all Control for Safety [TCS] menu on the Food Temperature				
	guidelines, food an	re not within recommended Id/or fluids are reheated to atures before service, and,				
	- TCS hot foods sh F or higher.	ould be served at 135 degrees	3			
	EQUIPMENT / ST	ORAGE:				
	completed with die single, automatic c which had visible r substance running backing of the devi	p.m. an initial kitchen tour was tary manager (DM)-A. A an opener was on the counter ed colored debris and dried down the rear, forward facing ice. A large floor based mixer ered with a clear bag. The bag				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _			
		00085	B. WING			C 10/2018
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	AMARITAN SOCIETY		TH STREET			
		WINDON	I, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21025	Continued From pa	age 97	21025			
	found areas of whit smeared substance the extended arm p is located (directly single plastic conta on the counter whit Inside the containe	the mixer inspected which te colored, dried particles and e being stuck to the base of portion where the mixing shaft above the mixing bowl). A ainer of powdered sugar was ch was approximately 1/4 full. er, a stainless steel, round o was sitting on top of the				
	acknowledged the	at the same time, DM-A observations of the soiled ted the scoop should not be iner.				
	listing identified sev completed. A bulle complete " any o done," and "kitcher leave!" In addition sheets were review	d Day and Evening Cook's veral cleaning tasks to be etpoint directed staff to ther cleaning that needs to be n should be spotless when you , provided weekly cleaning ved and lacked any directed ors, windows, screens nor fans				
	A policy on food eq requested, but not	uipment cleaning was provided.				
	The dietary manag importance of prop food. An audit cou the temperature of appropriate range.	THOD OF CORRECTION: ler could inservice staff on the per serving temperature of add be implemented to ensure the food is within the The results of the audit could e quality assurance committee				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	3) DATE SURVEY COMPLETED C
		00085	D. WING		08/10/2018
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET , MN 56101		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
21685	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685		9/19/18
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	blant. The physical plant, brs, ceilings, all furnishings, oment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.			
	by: Based on observati review, the facility fa sanitary environmendebris in 1 of 1 mai prepare and serve to failed to ensure fluid machines were kep in 1 of 3 kitchenette	ent is not met as evidenced on, interview and document ailed to provide a clean, nt which was free of dust and n production kitchens used to food. In addition, the facility d and/or ice dispensing of in a clean, sanitary manner es used. These findings had ffect all 78 residents currently ty.		Corrected	
	Findings include:				
	completed. A crant along the south side dietary manager's of screen covering the window. The scree of thick clumping du splatters of white an droppings. In addit was attached to the The fan blades' eac	b.m. the initial kitchen tour was k-style window was observed e of the kitchen next to the office with a visible metallic e entire, inner aspect of the en had numerous visible areas ust, with cobwebs and several nd black colored bird ion, a single oscillating fan e wall in the soiled dishes area. ch had visible, clumping black ed to the surfaces of the			

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00085	B. WING			C 10/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET , MN 56101			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
21685	Continued From pa	ge 99	21685			
	blades. The fan wa	s not turned on at this time.				
	11:20 a.m. the wind to have the same a clumping dust. The	observation on 8/7/18, at low screen and fan continued ppearance with visible ere was no visible evidence the had been cleaned since first				
	(DM)-C observed a the window screen kitchen. DM-C stat maintenance when and there was no for assigned to it. DM- several weeks sinc Further, DM-C state	a.m. the dietary manager nd verified the appearance of and fan in the main production ed the fan was cleaned by they were notified to do so, ormal cleaning schedule C expressed it had likely been e the fan was last cleaned. ed maintenance would also be n the window screen.				
	listing identified sev completed. A bulle complete " any of done," and "kitchen leave!" In addition, sheets were review	d Day and Evening Cook's veral cleaning tasks to be tpoint directed staff to her cleaning that needs to be a should be spotless when you provided weekly cleaning red and lacked any directed ors, windows, screens nor fans				
	No policies on kitch maintenance were					
	was observed. As counter which had dispensed. The su behind the spigot w	o.m. the central kitchenette ingle juice machine was on the one spigot of juice able to be rface area of the machine ras visibly soiled with dried, unning from the spigot area				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			_		С	
		00085	B. WING		08/	10/2018
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WINDOM	H STREET I, MN 56101			
(X4) ID		TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
PREFIX TAG		SC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
21685	Continued From pa	age 100	21685			
	automatic ice dispe- counter. The mach flaky, dried sedime surface of the devic inside the attached spigot automatic co- white colored sedim along the seam for tray attached to the On 8/7/18, at 8:00 a observed again. Th continued to be soi 8/6/18, with no evic	a.m. the kitchenette was he same observed devices led as previously viewed on lent cleaning being completed.) the kitchenette was toured				
	acknowledged the should be cleaned would let them kno DM-A provided a w The undated Thurs	findings and stated the area by the evening cooks, and she w. eek listing of cleaning duties. day Cleaning Duties listing				
		lean up juice machine." aning Duties directed staff to, achine sides to."				
	directed the evenin	d Evening Cooks listing g cook staff to clean the coffee cify how often this was to be				
	The administrator of dietary manager to to ensure dust, deb cleaned to maintair	THOD OF CORRECTION: or designee could work with the develop a cleaning schedule oris, and kitchenettes are n a safe, clean, environment. or designee could educate all				

ATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		00085	B. WING			
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		TH STREET M, MN 56101			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From pa	age 101	21685			
		n the program, and could g systems to ensure ongoing				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				