Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 9, 2023

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

RE: CCN: 245595
Cycle Start Date: February 16, 2023

Dear Administrator:

On February 16, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by May 16, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 16, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING _____ B. WING _____	C 02/16/2023

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

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E 000	Initial Comments On 2/13/23 throught 2/16/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/13/23 through 2/16/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed:: H5595028C (MN80446), H55958378C (MN89711), and H55958379C (MN88239), with deficiencies issued at F602, F609, and F610. The following complaints were reviewed with no deficiency issued: H559495C (MN86773) and H5595440C (MN85998). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

Electronically Signed | 03/17/2023

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		3/29/23

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F 584	Continued From page 2 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure comfortable warm water temperatures were maintained for 12 of 29 residents (R1, R3, R4, R5, R11, R13, R17, R18, R19, R21, R25, and R181) who resided on the 100-wing. Findings include: Interview on 2/13/23 at 1:34 p.m., with R19 identified the water was "too cold" for bathing or washing up. R19 revealed she gets a bath 2 times a week. The water in her room was "always cold. Everybody knows about it... they just tell us our rooms are at the end of the hall and there is nothing they could do about it". Observation on 2/13/23 at 2:29 p.m., in R19's room identified the hot water tap in bathroom had been turned on to its fullest extent. The hot water was allowed to run for 3 minutes and remained cold to the touch. Observation and Interview on 2/13/23 at 3:08 p.m., with R13 identified when she would use the bathroom sink in her room to wash up in the morning and had been unable to get any hot	F 584	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. The deficient practice noted the facility failed to ensure comfortable warm water temperatures were maintained for 12 of 29 residents. Plumbing contractor rerouted water flow to leverage water pumps on instant water heaters. Rerouting the flow of water and leveraging the water pumps improved the flow and shortened the length of time warm water reached 12 of the 29 residents.	

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F 584	Continued From page 3 water. R13 had notified the staff at the facility several times. Staff had told her the water heater was on the other side of the building and there was nothing they could do to "fix" it. The hot water was then turned on and allowed to run approximately 4-5 minutes and remained cold to touch. Interview on 2/14/23 at 1:59 p.m., with nursing assistant (NA)-A identified she typically had to turn on the hot water in all resident rooms on the 100 wing for several minutes prior to using it as it "never gets hot". NA-A revealed when water temps failed to get warm enough for comfort, she would either only wet a small corner of the washcloth to wash up the residents, or she had used a product called Peri-Wash spray that used little to no water instead. NA-A reported the lack of hot water down that wing approximately two months ago to the maintenance director (MD) and was told that a "ticket" was in to have the hot water problem fixed, however she was unsure of any outcome as the water remained well below comfortable temperatures for resident bathing. Interview on 2/14/23 at 2:57 p.m., with NA-B identified she was under the impression the water down the 100-wing failed to get warm enough for bathing because the hot water heater was on the opposite side of the building from the 100-wing. Interview on 2/14/23 at 3:02 p.m., with NA-C indicated the resident rooms on the 100-wing of the facility require a longer run time to get hot water. NA-C revealed she had told residents she was "sorry" she had been unable to get the water any warmer and "if she had been able to fix it herself...she would".	F 584	2. All residents have the potential to be affected by the deficient practice. The contractor rerouted two water sources to the instant water heater pumps. The water pumps improved the flow and shortened the length of time warm water reached 12 of the 29 residents. The recommended temperature range, at point of use, is between 110 and 115 degrees Fahrenheit. 3. To ensure systemic changes are made, the Maintenance Director will be educated on the Water Temperature policy to ensure compliance is maintained by the Administrator or designee. 4. The Maintenance Director or designee will conduct 2 random audits weekly for 4 weeks, then 2 random audits every 2 weeks for 8 weeks. Audits results will be brought to the monthly QAPI meeting to ensure solution is sustained. Warm water update is to be communicated to Resident Council. 5. The correction date will be March 29, 2023. The Administrator or designee will be responsible.	

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F 584	Continued From page 4 Observation and interview on 2/14/23 at 3:26 p.m., maintenance director (MD) identified 2 rooms were checked for appropriate water temperatures. R19's room hot water temperature was 80.7 degrees Fahrenheit (F). R18's room hot water temperature was 88.7 degrees F. The MD indicated the facility had trouble getting the water temperature to an acceptable range for the residents on the 100-wing. The MD revealed when she had been completing her routine hot water temperature audits, she would turn on the hot water in each room and lets it run "awhile". She would then go back to the first room she had turned the water on and started checking temperatures so "the hot water had time to warm up". Facility policy was to have hot water temperatures between 105-110 degrees within "a minute or two" of turning the hot water on. Review of the 1/6/23, Logbook Documentation indicated hot water temperature ranges for tap water was to be within 110 degrees to 115 degrees F, however, the logged temperatures identified that the hot water in the 100 wing resident rooms was between 53.6 degrees and 101 degrees. Interview on 2/14/23 at 3:45 p.m., with the administrator identified hot water temperature was to be maintained at acceptable ranges for comfort and safety between 105 F and 110 F.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 602		3/29/23

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F 602	Continued From page 5 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and doument review, the facility failed to protect resident medication from misappropriation of resident propertyby securing away from unauthorized use when 1 of 1 staff (licensed practical nurse (LPN)- A) diverted medication from a discharged resident (R180) for personal use. Findings include: Review of the 12/29/22 at 8:35 a.m., State Agency (SA) report identified an allegation of licensed practical nurse (LPN)-A, taking a dose of Zofran (nausea medication) belonging to R180 during the night shift on 12/28/22. R180 had been discharged on 12/1/22, and the medication had been stored in a plastic bag, unsecured from access by staff in the medication room pending destruction. The SA report identified LPN-A had not been feeling well during her scheduled shift and she had taken 1 Zofran (a medication used to treat nausea and vomiting) from the plastic bag. LPN-A reported during the shift report on 12/28/22 at 6:00 a.m., she had taken one Zofran tablet from the bag of medication which was to be destroyed for R180 as she felt ill during work. R180's signed physician orders identified an order dated 9/26/22 for Zofran 4 milligrams (mg) by mouth (PO) every (Q) 8 hours (H) as needed (PRN) for nausea. R180's physician orders for discharge did not include the Zofran, and the medication was placed in a plastic bag stored in	F 602	1. The deficient practice noted the facility failed to protect resident medication from misappropriation of resident property by securing away from unauthorized use when 1 of 1 staff diverted medication from a discharged resident for personal use. All medications for the discharged resident were destroyed. The nurse who diverted the discharged resident s medication received disciplinary action, was educated at time of disciplinary action, and had to review the Drug Diversion Policy and Procedure. The Occurrence was also reported to the Board of Nursing and law enforcement. 2. All residents in the facility have a potential to be affected by the same deficient practice. All residents medications requiring destruction will be monitored by DNS or designee, kept in med room, and destroyed within 72 hours of being discharged or expired. Licensed and TMA staff who have the potential to divert medications were educated. 3. To ensure systemic changes are made, all licensed nurses and TMA s will be trained/educated on the Medication: Disposition (Disposal) policy of unused portions of medications remaining in the facility after a residents death or discharge by the DNS or designee.	

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F 602	Continued From page 6 the medication room for destruction. Interview on 2/14/23 at 2:17 p.m., with the social services designee (SSD) reported she received report of the incident from trained medication aide (TMA)-A during the morning of 12/28/22 when she had come to work. The SSD reported TMA-A had come to her and reported during shift report at 6:00 a.m., LPN-A stated she was not feeling well, was not able to find someone to complete her shift, and had taken a Zofan that was in the medication room for destruction. The SSD reported she had been told by TMA- A, LPN-A stated she had a personal prescription for Zofran at home, but did not have any with her at work, so she had taken one of the pills to enable her to finish her shift. The administrator was not available at the time, so the incident was reported to the director of nursing (DON)-B. DON-B and SSD interviewed TMA-A, reviewed the video recording of the medication room for 12/28/22 night shift, but did not observe LPN-A taking the medication. LPN-A was contacted via phone by administrator-B and admitted she had taken one Zofran pill from the plastic bag containing R180's medication. The SSD reported following the facility investigation and consultation with the Corporate Human Resources (HR) department administrator-B had submitted a report to the SA. The corporate HR made the decision to file a report to the Board of Nursing, and issue a final written action to LPN-A in addition to providing re-education. The SSD reported HR advised administrator-B a report to law enforcement was not necessary because R180 had been discharged on 12/1/22, the incident did not take place until 12/28/22, and the medication was no longer R180's personal property since it was to be destroyed.	F 602	4. The DNS or designee will conduct audits to ensure that those residents that had discharged or expired had their medications destroyed. Audits will be completed weekly for three months. The results will be reported to the QAPI committee for review and recommendations. The QAPI committee will determine if further auditing needs to are necessary. 5. The correction date will be March 29, 2023. The DNS or designee will be responsible.	

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F 602	Continued From page 7 Interview on 2/14/23 at 3:08 p.m., with TMA-A reported at shift report on 12/28/22 at about 6 a.m., LPN-A reported she had been ill during her overnight shift, there was no one available to cover her shift and she had recalled there was Zofran in the medication room from a resident that had been discharged. TMA-A reported LPN-A stated she could not leave as she was the only nurse on duty, she had a personal prescription for Zofran, but did not have any with her, so she had taken one of the Zofran pills. TMA-A reported she knew this was wrong and she had reported the incident to the SSD who stated she would report the incident to the administrator and DON. Interview on 2/14/23 at 6:00 p.m., with LPN-A reported she had worked the overnight shift on 12/28/22 and had become ill. LPN-A reported she had a history of gastric issues and had developed nausea, vomiting and diarrhea. LPN-A reported she had contacted DON-B and the infection preventionist but neither of them were available to replace her shift. LPN-A reported she remembered seeing the bag containing the Zofran in a bag of medications to be destroyed in the medication room. LPN-A reported she was aware that it was not acceptable to take the medication, but since the resident had been discharged, and the medication was to be destroyed, she felt it was ok to take one of the Zofran tablets. LPN-A had a personal prescription for the medication, but did not have any with her and she knew she had to get through her shift and so she had taken one of the Zofran pills from the bag to be destroyed. LPN-A reported she finished her shift and had mentioned she had taken the Zofran from the medication room during report. Later that	F 602		

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F 602	Continued From page 8 morning LPN-A reported she received a phone call from DON-B and the SSD and when questioned had admitted she had taken the one Zofran pill and why she had done so. She was informed the incident had to be reported to the SA and she would need to meet with administrator-B and HR. LPN-A reported she had a meeting with administrator who reviewed the facility policy on medication destruction and diversion of medications, and issued her a written warning. The nurse consultant was also involved, and she was informed the incident had been reported to the Board of Nursing. LPN-A reported education was provided to all nursing staff on the policies for medication destruction and drug diversion. LPN-A stated she was aware taking the medication was "wrong", but she felt she had no other option due to the situation of needing to be able to finish her shift. R180 was not able to be reached for interview on 2/14/22 at 3:00 p.m. or 2/17/22 at 10:30 a.m. Interview on 2/17/23 at 10:00 a.m. with DON-A reported she was just starting in her position as DON at the time of the incident and did not recall a lot of the investigation, but agreed it was drug diversion to take a medication that had been prescribed for a resident She was aware taking a medication was reportable to the SA and reported the steps in the investigation process. The facility policy was provided. Review of the August 11, 2020 Drug Diversion policy identified diversion as the removal of drugs for the employee or others use and included on or off the facility premises. If the investigation revealed suspicion the notifications were to include the facility administrator, the SA, law	F 602		

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	245595	A. BUILDING _____ B. WING _____	C 02/16/2023

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F 602	Continued From page 9 enforcement and other designated agencies in accordance with state law of a medication diversion. This is viewed as misappropriation of resident property.	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 609	1. The deficient practice noted the	3/29/23

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F 609	Continued From page 10 facility failed to follow their policy to report an allegation of a crime (drug diversion) to the State Agency (SA) and law enforcement in a timely manner for 1 of 1 resident (R180). Findings include: Review of the 12/29/22 at 8:35 a.m., State Agency (SA) report identified an allegation of licensed practical nurse (LPN)-A, taking a dose of Zofran (nausea medication) belonging to R180 during the night shift on 12/28/22. R180 had been discharged on 12/1/22, and the medication had been stored in a plastic bag, unsecured from access by staff in the medication room pending destruction. The SA report identified LPN-A had not been feeling well during her scheduled shift and she had taken 1 Zofran (a medication used to treat nausea and vomiting) from the plastic bag. LPN-A reported during the shift report on 12/28/22 at 6:00 a.m., she had taken one Zofran tablet from the bag of medication which was to be destroyed for R180 as she felt ill during work. R180's signed physician orders identified an order dated 9/26/22 for Zofran 4 milligrams (mg) by mouth (PO) every (Q) 8 hours (H) as needed (PRN) for nausea. R180's physician orders for discharge did not include the Zofran, and the medication was placed in a plastic bag stored in the medication room for destruction. Interview on 2/14/23 at 2:17 p.m., with the social services designee (SSD) reported she received report of the incident from trained medication aide (TMA)-A during the morning of 12/28/22 when she had come to work. The SSD reported TMA-A had come to her and reported during shift report at 6:00 a.m., LPN-A stated she was not feeling well, was not able to find someone to complete	F 609	facility failed to protect resident medication from misappropriation of resident property by securing away from unauthorized use when 1 of 1 staff diverted medication from a discharged resident for personal use. All medications for the discharged resident were destroyed. The nurse who diverted the discharged resident s medication received disciplinary action, was educated at time of disciplinary action, and had to review the Drug Diversion Policy and Procedure. The Occurrence was also reported to the Board of Nursing and law enforcement. 2. All current and new residents have the potential to be affected by the same deficient practice. Notification of law enforcement and other designated agencies in accordance with state law of medication diversion will be followed. 3. To ensure systemic changes are made, all licensed nurses and TMA s will be trained/educated on the policy, Medication: Missing/Diversion of Medication by DNS or designee. 4. The DNS or designee will conduct audits to ensure that those residents that discharge or expire have their Medications destroyed within 72 hours. Audits will be completed weekly for three months. The results will be reported to the QAPI committee for review and recommendations. The QAPI committee will determine if further auditing needs are necessary.	

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F 609	Continued From page 11 her shift, and had taken a Zofan that was in the medication room for destruction. The SSD reported she had been told by TMA- A, LPN-A stated she had a personal prescription for Zofran at home, but did not have any with her at work, so she had taken one of the pills to enable her to finish her shift. The administrator was not available at the time, so the incident was reported to the director of nursing (DON)-B. DON-B and SSD interviewed TMA-A, reviewed the video recording of the medication room for 12/28/22 night shift, but did not observe LPN-A taking the medication. LPN-A was contacted via phone by administrator-B and admitted she had taken one Zofran pill from the plastic bag containing R180's medication. The SSD reported following the facility investigation and consultation with the Corporate Human Resources (HR) department administrator-B had submitted a report to the SA. The corporate HR made the decision to file a report to the Board of Nursing, and issue a final written action to LPN-A in addition to providing re-education. The SSD reported HR advised administrator-B a report to law enforcement was not necessary because R180 had been discharged on 12/1/22, the incident did not take place until 12/28/22, and the medication was no longer R180's personal property since it was to be destroyed. Interview on 2/14/23 at 3:08 p.m., with TMA-A reported at shift report on 12/28/22 at about 6 a.m., LPN-A reported she had been ill during her overnight shift, there was no one available to cover her shift and she had recalled there was Zofran in the medication room from a resident that had been discharged. TMA-A reported LPN-A stated she could not leave as she was the only nurse on duty, she had a personal prescription for	F 609	5. The correction date will be March 29, 2023. The Administrator or designee will be responsible.	

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F 609	Continued From page 12 Zofran, but did not have any with her, so she had taken one of the Zofran pills. TMA-A reported she knew this was wrong and she had reported the incident to the SSD who stated she would report the incident to the administrator and DON. Interview on 2/14/23 at 6:00 p.m., with LPN-A reported she had worked the overnight shift on 12/28/22 and had become ill. LPN-A reported she had a history of gastric issues and had developed nausea, vomiting and diarrhea. LPN-A reported she had contacted DON-B and the infection preventionist but neither of them were available to replace her shift. LPN-A reported she remembered seeing the bag containing the Zofran in a bag of medications to be destroyed in the medication room. LPN-A reported she was aware that it was not acceptable to take the medication, but since the resident had been discharged, and the medication was to be destroyed, she felt it was ok to take one of the Zofran tablets. LPN-A had a personal prescription for the medication, but did not have any with her and she knew she had to get through her shift and so she had taken one of the Zofran pills from the bag to be destroyed. LPN-A reported she finished her shift and had mentioned she had taken the Zofran from the medication room during report. Later that morning LPN-A reported she received a phone call from DON-B and the SSD and when questioned had admitted she had taken the one Zofran pill and why she had done so. She was informed the incident had to be reported to the SA and she would need to meet with administrator-B and HR. LPN-A reported she had a meeting with administrator who reviewed the facility policy on medication destruction and diversion of medications, and issued her a written warning.	F 609		

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F 609	Continued From page 13 The nurse consultant was also involved, and she was informed the incident had been reported to the Board of Nursing. LPN-A reported education was provided to all nursing staff on the policies for medication destruction and drug diversion. LPN-A stated she was aware taking the medication was "wrong", but she felt she had no other option due to the situation of needing to be able to finish her shift. R180 was not able to be reached for interview on 2/14/22 at 3:00 p.m. or 2/17/22 at 10:30 a.m. Interview on 2/17/23 at 10:00 a.m. with DON-A reported she was just starting in her position as DON at the time of the incident and did not recall a lot of the investigation, but agreed it was drug diversion to take a medication that had been prescribed for a resident She was aware taking a medication was reportable to the SA and reported the steps in the investigation process. The facility policy was provided. Review of the August 11, 2020 Drug Diversion policy identified diversion as the removal of drugs for the employee or others use and included on or off the facility premises. If the investigation revealed suspicion the notifications were to include the facility administrator, the SA, law enforcement and other designated agencies in accordance with state law of a medication diversion. This is viewed as misappropriation of resident property.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 610		3/29/23

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F 610	Continued From page 14 must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to appropriately assess and implement interventions to ensure residents were free from resident to resident abuse for 4 of 4 residents (R8, R9, R178 and R179). Findings include: Review of the 1/24/22, report to the State Agency (SA) identified R178 was wheeling himself past R5 in front of the nursing station when R5 hit R 178 on his right arm just below his shoulder with the back of her hand. R 178 continued past R5 without stopping. The 1/31/22 5 day investigation report identified R5 was looking for a man who "ripped her off" and is a "crook". R 178 was in his wheelchair going past R5 who was in her wheelchair heading the opposite direction toward the dining room. R5 stuck her hand out and made contact with R178's right upper arm. R178 said "ouch" and pulled his arm back. R178	F 610	1. The deficient practice noted the facility failed to appropriately assess and implement interventions to ensure residents were free from resident-to-resident abuse for 4 of 4 residents. Assessments were completed and interventions were put into place for residents. 2. All residents in the facility have a potential to be affected by the same deficient practice. All residents have been assessed to ensure they are free from resident-to-resident abuse. Staff will be educated to monitor residents abuse and neglect and implement interventions immediately. 3. To ensure systemic changes are made, all staff will be educated on the abuse and neglect policy. Also,	

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F 610	Continued From page 15 continued down the hall and did not stop. Interview with R178 after the incident reported he was wheeling past R5 and she had "swatted" him on his arm. R178 commented the area was going to be purple tomorrow. A skin observation completed by the charge nurse on 1/24/22 and repeated on 1/25/22. There was no documentation in the medical record of further investigation or review by the interdisciplinary team (IDT) into the root cause of R5 striking R178. the facility identified both residents were being kept separated as best as possible by staff. R8 was checked for a urinary tract infection (UTI) which came back negative and was scheduled to have a special visit with her primary doctor on 2/8/22 to review her mood and behavior. Review of the 1/24/22 at 4:15 p.m. facility incident report for R178 identified R8 had struck out at R178 and contacted his right upper arm. R178's right upper arm was checked and there was no sign of bruising or injury noted. R178 reported "it had hurt right away but not anymore". There was no update to the care plan or interventions added on how staff were to provide for R178's safety and preventing further potential abuse. Review of the 9/13/22 initial report to the SA identified R8 and R9 were both seated in their wheelchairs by the nursing station. R9 stated that R8 had slapped his outer thing on his left leg then grabbed his pant leg and wouldn't let go. R9 reported it did not hurt, did not traumatize him and he was not upset. The 9/20/22 5 day investigation identified R5 was upset when she was in the dining room and had verbally threatened to hit dietary aide (DA)-A and was yelling and swearing. R5 had refused to leave the dining room and nursing assistant (NA)-B	F 610	Interdisciplinary Team members will be educated on the reported incidents and immediate interventions implemented to ensure residents are free from resident-to-resident abuse by Social Services or designee. 4. Observation audits will be conducted by DNS or designee for all residents regarding resident-to-resident abuse and intervention success. Audits will be conducted weekly for three months to ensure residents are free from resident-to-resident abuse. Audit results will be brought to the monthly QAPI meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Correction date 03/29/2023- DNS or designee will be responsible.	

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F 610	Continued From page 16 returned later and were able to transport R5 from the dining room. Both R8 and R9 were by the nursing station when NA-B returned to the area and observed R8 holding onto R9's pants. NA- B immediately separated R8 and R9 and R8 was taken to a quiet area and given a doll which she could put to sleep. When interviewed R9 reported he had gone to the nursing station to have someone help him find something and reported he was not hurt or traumatized. R9 denied any fear of being out of his room or of R8, and stated, "she just gets ornery sometimes." Action taken to prevent reoccurrence was Education/communication to staff regarding offering non-pharmacological interventions listed in R8's care plan or from the intervention cabinet when R8 was worked up, had high anxiety or was over stimulated. There was no mention of interventions put into place or how staff were to prevent further potential abuse. Review of the 11/4/22, initial report to the SA identified R8 and R179 were heard bickering in the dining room by the administrator (previous administrator)-B. Upon arrival at the dining room R8 and R179 were about 3 feet apart and the administrator attempted to remove R8 from the dining room, and as she was being moved she attempted to kick R179, but was not close enough to make contact. As R8 was being moved away she attempted to strike the administrator. R179 received a bruise and a scratch on her left arm and elbow. The 11/11/22 5 day investigation identified staff failed to separate R8 and R179 when R8 became agitated. R8 became agitated and began yelling at a staff member calling her names. R179 stepped in and told R8 not to say those types of tings to that staff member as R179 liked that staff	F 610		

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F 610	Continued From page 17 member. the staff member walked away as that was usually effective in calming R8. Immediate intervention was to separate the 2 residents from each other. Staff education was provided via On Shift to separate the residents if R8 was becoming agitated with another resident. Education was required to all staff for "Dementia Care: Challenging Behaviors and Direct Care Staff", R8's care plan was updated and placed at the nursing station for all staff to review and sign. R8's, 9/23/22 annual Minimum Data Set (MDS) assessment identified severe cognitive impairment, behaviors of physical symptoms directed toward others occurred 4-6 days during the assessment period, verbal behavior directed toward others occurred 1-3 days, and other behavior symptoms not directed toward other occurred 4-6 days. For activities of daily living (ADLs) R8 required Extensive assistance from 2 staff persons for bed mobility, transfers, dressing, and toileting. One staff assistance was needed for personal hygiene and locomotion on/off the unit and was not able to ambulate. R8 was always incontinent of bladder and frequently incontinent of bowel. R8 had diagnosis including non-traumatic brain dysfunction, hypertension, arthritis, dementia, anxiety disorder, and depression. R8 received scheduled pain, anxiety, and psychotropic medications. R8's undated care plan identified she had impaired thought process, was monitored for increased confusion or forgetfulness and had limited physical mobility. R8 was evaluated by Occupational therapy and used a low-scoot chair. R8 had increased anxiety at times and was repetitive and over stimulated by residents. Interventions included redirection by offering to	F 610		

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F 610	Continued From page 18 watch TV in her room, reading, organizing belongings, hold her cat or doll, offer a book to read or coffee. If a resident to resident altercation occurred, staff were to separate the residents, keep all residents safe and offer non-pharmacological interventions. If combative with cares, staff were to leave R8 in a safe position and re-approach later. R9's, 10/14/22, annual MDS identified R9 had moderate cognitive impairment, had no identified behaviors, and required Extensive assistance of 2 staff for bed mobility, 1 person assist with transfers, locomotion on/off the unit, dressing, toileting and personal hygiene. R9 required limited assistance of one staff for walking in his room, and supervision for walking in the hall. R9 had diagnosis of medically complex conditions, Coronary artery disease, hypertension, hyperlipidemia, and Parkinson's disease. R9's undated care plan identified he had limited physical mobility, weakness, bilateral leg pain and Parkinson's disease. R9 needed assist of 1 staff with a gait belt for mobility. Staff were to protect resident from potential abuse. R9 was receiving a restorative program and received an antipsychotic for adjustment disorder and an antidepressant for depressed mood with monitoring for potential side effects. R178's, 11/29/21, admission MDS identified moderate cognitive impairment, ADLs were independent to supervision with all areas and R178 used a walker and wheelchair for mobility. R178 had a history of falls prior to admit, and diagnosis which included coronary artery disease, weakness, hypertension, and malignant neoplasm of prostate.	F 610		

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F 610	Continued From page 19 R178's undated care plan identified he had limited physical mobility related to (R/T) a history of a motor vehicle accident (MVA) with a sternal fracture, weakness and used a w/c for locomotion, and was able to ambulate independently. Staff were to protect all residents from potential allegations of resident abuse, neglect, exploitation or mistreatment. The care plan identified R178 required assistance from one staff for ADLS. R178 had a psychosocial well-being deficit evidenced by calling staff servants. Non-pharmacological interventions included 1:1, playing cards, puzzles, and he received antidepressant medication R/T a diagnosis of anxiety. Mood and behavior identified R178 was short tempered with staff, made negative comments towards staff, mocked other residents, and had been being physically aggressive. Interventions included for staff to intervene as necessary to protect the rights and safety of others and approach/speak in a calm manner, divert attention, remove him from the situation and take to alternate location as needed. R178 had a history of physical aggression with other residents. that was noted when he was in an over stimulated environment and R178 had decreased patience. If a resident to resident altercation occurred staff were to separate the residents, keep all residents safe, and offer non-pharmacological interventions included in care plan. There were no interventions included to identify an individualized approach with regard to the altercation with R8. R179's, 12/13/22. discharge with return anticipated MDS identified her cognition was intact, she had moderate to severe depression, behaviors included delusions, and she required	F 610		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 20 extensive assistance of 2 staff for bed mobility, and the assistance of one staff for transfers, locomotion on/off the unit, dressing, toileting, and personal hygiene. R179 had diagnosis of osteoarthritis of knee, heart failure, hypertension, arthritis, vision issues, morbid obesity and major depressive disorder, and occasional pain. R179 had been on isolation due to COVID-19 and was paranoid of facility staff. R179's, 10/20/22, Care Area Assessment (CAA) identified cognitive loss/dementia, had disorganized thinking at times and would ramble and have irrelevant conversations due to her paranoia of facility staff. R179's, undated care plan identified she was able to verbally communicate her needs, had limited physical mobility and was at risk for falls R/T incontinence, medication use, weakness, congestive heart failure, and depression. R179 had an ADL self-care performance deficit and utilized a w/c for locomotion, and required an EZ stand lift for transfers. Behaviors were paranoia, being rude to "bullying" other residents, refusing to talk about mental health, many negative comments towards staff/belittles and degrades staff, and was rude to residents. Intervene as necessary to protect the rights and safety of others. Remove from situation and take to alternate location as needed. There was no mention of interventions specific to altercations with R8 or other residents. Interview on 2/13/23 at 6:15 p.m., with the SSD reported R8 had dementia with behavioral disturbances and became physically aggressive with cares. She reported there were not specific triggers or persons that R8 targeted but it seemed to be a situational response when she was agitated, or there was something not as she	F 610		

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F 610	Continued From page 21 thought it should be. She reported R8 became over-stimulated around other residents or if there were loud activities going on. R8 calmed down if staff were able to bring her to the lounge across from the nursing station and give her something to read, or take her to the living room and give her a baby doll to hold and put to sleep. The SSD reported R8 had received orders for a new pain medication (Fentanyl patch) that had been started the previous week and staff had noticed R8's mood had improved and she had decreased behavior. The SSD reported facility staff had received education on an annual basis on abuse, vulnerable adults, and reporting in addition to dementia training that was provided after the incident in November 2022. She reported staff were aware of R8's behavior and agitation directed toward other residents and staff and attempted to position R8 in a quieter area and supervise to keep other residents from getting too close, especially if R8 was agitated. Interview on 2/14/23 at 2:53 p.m., with nursing assistant (NA)-A reported R8 required total assistance from two staff for all ADLS and more recently had needed to be assisted with eating. NA-A reported R8 did seem more calm since the new medication had been started, but she continued to have verbal and physical aggression toward staff and other residents. She reported the immediate intervention when R8 became agitated toward another resident was to separate them, and take R8 to the living room and give her a doll to hold, or a book to read. She reported R8 was allowed to sleep in if she didn't want to get up, and 30 minutes prior to personal cares being provided R8 was given an antianxiety medication which helped with the aggressive behavior	F 610		

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F 610	Continued From page 22 directed toward staff. NA-A reported R8 liked her "alone" time and spent a lot of time sitting in the living room reading or watching TV. NA-A reported she had received education on abuse, rights, reporting and dementia training within the last year, and the dementia training was provided in November 2022. Interview on 2/16/23 at 8:30 a.m., with the DON reported she was new in her positron and just learning about the need to review and revise care plans and interventions. She reported her expectations for staff to follow the facility abuse and neglect policy for keeping all residents safe, and when an incident did take place it was to be reviewed by the management team, discussion to attempt to determine the cause, review of interventions in place, and care planing of any new interventions added.	F 610		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge	F 661		3/29/23

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F 661	Continued From page 23 medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete an appropriate discharge summary for 2 of 2 residents (R26 and R180) who were discharged to the community. Findings include: R26's 12/1/22, discharge Minimum Data Set (MDS) identified R26 had been independent with bed mobility, transfers, and toileting. R26 also required staff supervision when walking and was frequently incontinent of urine and occasionally incontinent of bowel. R26's 12/1/22, facility discharge summary identified pertinent medical diagnoses. It also had sections for hearing, vision and cognition which were blank. Staff noted mood and behavior as "happy to be going", and Activities of Daily Living noted "walker". Staff also noted resident's patterns of bladder and bowel were "ambulates to the bathroom". The discharge summary lacked any mention of course of illness, treatment, pertinent labs or consultations. R26's discharge summary also included a section giving direction	F 661	1. The deficient practice noted the facility failed to ensure a comprehensive discharge summary, including a recapitulation of stay, completed and communicated with the resident or the receiving healthcare provider (i.e. home care) to promote continuity of care and reduce the risk of complications within the discharge process. The resident was discharged on 12/01/2022. 2. All facility residents that desire discharge back to a community setting or transferring to another healthcare facility are at risk to be affected by alleged deficient practice. The DNS will monitor all residents who have the potential to discharge to ensure discharge process is followed. 3. To ensure systemic changes are made, all licensed nurses will be educated on the comprehensive discharge procedure, including a recapitulation of stay, a completed and well communicated	

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F 661	Continued From page 24 for the licensed nurse to complete a recapitulation of resident's stay including diagnosis, course of illness, treatment or therapy, pertinent lab, radiology and consultation results. A final summary of the resident's status to include the resident's strengths, goals, life history and preferences as reflected in the MDS. R180's 12/1/22, Discharge return not anticipated MDS identified R180 had moderate cognitive impairment and required limited assistance for toileting, supervision for all other Activities of Daily Living (ADL), and was able to ambulate independently in her room. R180 had diagnoses of osteoporosis, beeding of her brain stem, enlarged heart, abnormalities of gait and mobility, and hemiplegia(paralysis on 1/2 of the body). R180's 12/1/22 at 10:30 a.m., discharge summary identified diagnoses that were present on admission, with a space for final diagnosis to be completed by the physician with signature and date were left blank. The section identified as resident strengths and goals were also not completed on the discharge summary. Interview on 2/16/23 at 9:29 a.m., with the director of nursing (DON) indicated R26's discharge summary was missing a large amount of information that she would have expected to be included. The DON agreed R26's discharge summary did not include a recapitulation of care. Review of the 12/22/22, Discharge Planning Policy with a check list attached indicated a Discharge/Therapeutic Leave Instructions Progress Note and a Discharge Summary should have been completed in the medical record, however, there was no mention of a recapitulation	F 661	summary of the resident to the receiving healthcare provider (i.e. home care) to promote continuity of care and reduce the risk of complications within the discharge process. 4. The DNS or designee will conduct audits weekly for three months on all discharges to ensure compliance. DNS will review discharge summaries and provide education to licensed nursing staff. Audit results will be brought to the monthly QAPI meeting with appropriate follow up indicated to ensure solutions are sustained. 5. Facility will be in compliance on 3/29/23, DNS/designee will be responsible for compliance.	

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F 661	Continued From page 25 of resident's stay.	F 661		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer medication according to manufactures guidelines and physician's orders for 2 of 31 observations, resulting in a 6.4% medication error rate. Findings include: Observation and interview on 2/16/23 at 7:57 a.m., of R10's medication pass with trained medication aide (TMA)-A who gathered his morning medications identified TMA-A administered his omeprazole (blocks stomach acid) and his albuterol inhaler. R10's inhaler label had an expiration date of 2/1/23 and was last used on 2/9/23. TMA-A reported R10's omeprazole was to administered before meals, but due to busy medication pass times, it would commonly end up being given with or immediately after R10 had his meal. TMA-A agreed R10's Albuterol inhaler label should have been verified as part of the 5 rights of medication administration and identified prior to administration. R10's current, undated physicians orders identified R10 had an order for omeprazole 20	F 759	1. The deficient practice noted the facility failed to administer medication, including scheduling, according to manufacturer guidelines and physician orders for 2 of 31 observations. The nurse involved in the medication error has been educated on the Six Rights of Medication Administration. 2. All facility residents that take medications in the facility have the potential to be affected by medication errors. Education on medication administration was conducted on 2/16/23. 3. To ensure systemic changes are made, all licensed nurses and TMAs will be educated on medication administration including scheduling and Medication Aides policy. Per policy, six rights will be followed for medication administration. Education for all licensed nurses and TMA s will be completed by the DNS or designee. 4. Random audits of policy Medication: Administration Including Scheduling and	3/29/23

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F 759	Continued From page 26 milligrams (MG) by mouth (PO) twice daily (BID) to be taken before meals (ac) and Albuterol Sulfate 90 microgram (MCG) inhaler, 1 puff PO every 4 hours as needed (PRN). Interview on 2/16/23 at 8:38 a.m., with the DON identified she expected medications were to be administered according to the signed doctor's orders and discarded per manufacturer's instructions. The medication cart had been last checked by the Pharmacist on 1/25/23 and the TMA completed a check on 1/29/23. The DON was not certain how the inhaler was missed when both the consultant pharmacist and a TMA had checked the cart for outdated medications. The DON was aware medications such as omeprazole was being administered with meals rather than as order by the physician or indicated per manufacturer's guidelines. Review of the August 24, 2022, Administration Including Scheduling and Medication Aides policy identified medication was to be administered correctly and in a timely manner. The 5 Rights of Medication administration were to be followed for medication administration.	F 759	Medication Aides will be conducted by the DNS or designee, 3 times weekly for 4 weeks and then 1 time per week for 8 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained. 5. Facility will be in compliance on 3/29/23, DNS/designee will be responsible for compliance.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		3/29/23

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F 761	Continued From page 27 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure controlled medication was appropriately and securely stored to prevent potential drug diversion during observation of medication storage for 1 of 1 resident (R18) when their lorazepam was found partially opened and taped back in the original blister pack container. Findings include: Observation on 2/14/23 at 11:24 a.m., of the medications stored in the double locked drawer of the medication cart identified one blister card with lorazepam 0.5 mg by mouth (PO) as needed (PRN), for R18. The back of the card was punched out and covered with a tape. The medication markings were consistent with the remainder of the lorazepam in the blister pack. Interview and document review on 2/14/23 at	F 761	1. The deficient practice noted the facility failed to ensure controlled medication was appropriately and securely stored to prevent potential drug diversion during observation of medication storage for 1 of 1 resident. Pharmacy will supply facility with RED DOT stickers that can be used when staff notice during routine narcotic counting the cards begin to show destruction/tear from being pulled in and out of the narcotic drawer. 2. All residents have the potential to be affected by the same deficient practice. All residents narcotics have been reviewed to ensure the same deficient practice does not exist. 3. To ensure systemic changes are made, all licensed nurses and TMAs will be re-educated on current	

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F 761	Continued From page 28 11:33 a.m., with trained medication aide (TMA)- A reported the medication cards stored in the double locked portion of the medication cart often became damaged due to the cards being taken in and out of the drawer during administration and again during the shift controlled medication counts. TMA-A felt that may be the reason for the partial opening on R18's card of lorazepam. Review of the narcotic book identified the count was correct for R18's lorazepam. Interview on 2/14/23 at 11:50 a.m., with the DON reported she was aware of the problem with damage to the medication cards when they were repeatedly taken in and out of the drawer. She was working with the pharmacy provider to correct. The DON provided a sticker system that was to be used when the packaging was damaged and reported this should have been implemented when the damaged card was discovered. The DON explained two staff (one being a licensed nurse) was to confirm the medication was still contained in the bubble pack on the card, and then a sticker with a dot was placed over the damaged area on the back of the card and dated and initialed by both staff. Review of the 2/13/23, Lewis Drug Sticker Policy/Procedure identified the purpose of the system was to avoid having to send medications back to the pharmacy for repackaging or destruction when the medication remained in the card, but the integrity of the package had been damaged, and there was risk that the medication would fall out of the card. Staff were not to use the stickers on narcotic medication. 2 staff were to follow affix a red dot stickers to the medication. Those stickers were not to be used for narcotics that had been accidentally punched out of the	F 761	policy/procedure, Medication: Pharmacy Sticker Policy/Procedure. Education for all licensed nurses and TMA s will be completed by the DNS or designee. 4. Random audits will be conducted by the DNS or designee, 3 times weekly for 4 weeks and then 1 time per week for 8 weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained. 5. Facility will be in compliance on 3/29/23, DNS/designee will be responsible for compliance.	

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F 761	Continued From page 29 card, or if a resident refused a medication that had been dispensed. The policy made no reference to medication that was not a narcotic but a controlled medication subject to being highly diverted.	F 761		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/14/2023. At the time of this survey, Good Samaritan Society-Westbrook was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 03/17/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building 01 of Good Samaritan Society Westbrook was constructed as follows: The original building was built in 1961, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction; The first addition was built in 1969, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(222) construction; The second addition was built in 2001, is	K 000		

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

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K 000	Continued From page 2 one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction Building 03 of Good Samaritan Society Westbrook includes a 2007 building addition, consisting of a new main entrance, lobby and offices. In 2011, the dietary department was fully remodeled. These additions are one-story, have no basement, are fully sprinklered and were determined to be of Type V(111) construction. The facility has a capacity of 32 beds and had a census of 30 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to maintain emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1, 7.8.2.1, and 7.9.2.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 02/14/2023 at 10:00AM, it was revealed by observation that the emergency light in the Electrical Room needs to be repaired or replaced.	K 291	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction	3/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 291	Continued From page 3 The emergency light did not fully illuminate when tested and was not properly mounted on the wall mounting bracket. An interview with Maintenance Director verified this deficient finding at the time of discovery.	K 291	constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. The deficient practice revealed the emergency light in the Electrical Room needed to be repaired or replaced. The Emergency Light in the Electrical room was replaced. 2. Administrator and Maintenance Director will review policies and procedures on Emergency Lighting to ensure this standard is met. 3. The policy and procedures are reviewed for the deficient practice to ensure compliance is maintained. Ensure emergency lighting in electrical room is included in facilities TELS system under Monthly frequency. Education of maintenance director is scheduled for the week of 3/20/2021. 4. Monthly audits for three months will be performed by Administrator or designee. Audits to be shared at monthly QAPI meeting to ensure ongoing compliance. 5. This deficiency was corrected on March 1, 2023.	
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		2/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 918	Continued From page 4 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.6.1 and NFPA 110 (2010	K 918	1. The deficient practice was revealed during a review of available documentation that during the January 2023 monthly 30-minute load test, it took 14 seconds to transfer power from normal	

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	245595	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2023**

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K 918	Continued From page 5 edition), Emergency and Standby Power Systems, sections 8.3 and 8.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/14/2023 at 11:00AM, it was revealed by a review of available documentation that during the January 2023 monthly 30 minute load test, it took 14 seconds to transfer power from normal to emergency power. An interview with the Maintenance Director, indicated that the monthly test was conducted on an extremely cold morning possibly delaying the power transfer. An interview with the Maintenance Director verified that this deficient finding at the time of discovery.	K 918	to emergency power. Generator was serviced and detected a bad block heater n generator. A new block heater was installed and was tested. 2. Administrator and Maintenance Director will review policies and procedures on Emergency and Stand by Power Systems, Generators to ensure this standard is met. 3. The policy and procedures will be reviewed for the deficient practice to ensure compliance is maintained. Ensure emergency generators is included in facilities TELS system under Monthly frequency. Education of maintenance director is scheduled for the week of 3/20/2021. 4. Monthly audits for three months will be performed by Administrator or designee. Audits to be shared at monthly QAPI meeting to ensure ongoing compliance. 5. This deficiency was corrected on February 22, 2023.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 9, 2023

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

RE: CCN: 245595
Cycle Start Date: February 16, 2023

Dear Administrator:

On April 25, 2023, we notified you a remedy was imposed. On April 5, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 29, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 16, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 9, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 16, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 29, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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