



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 28, 2023
Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

RE: CCN: 245207
Cycle Start Date: March 30, 2023

Dear Administrator:

On April 26, 2023, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 13, 2023

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

RE: CCN: 245207
Cycle Start Date: March 30, 2023

Dear Administrator:

On March 30, 2023, a survey was completed at your facility by the Minnesota Department of Health, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 June 30, 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 September 30, 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/lrc_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

Good Samaritan Society - Stillwater

April 13, 2023

Page 4

dates specified for compliance or the imposition of remedies.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 13, 2023

Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, MN 55082

Re: Event ID: 3NEO11

Dear Administrator:

The above facility survey was completed on March 30, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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

PRINTED: 04/21/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2023
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - STILLWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/30/23, a standard abbreviated survey was conducted at your facility. 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: H52079605C (MN92132 and MN92123) H52079939C (MN87143) with deficiencies issued at (F609 and F610) H52079844C (MN87142) with deficiencies issued at (F609 and F610) 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. 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 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,	F 609			4/21/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/21/2023

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.

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

PRINTED: 04/21/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2023
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - STILLWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082		
(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 609	Continued From page 1 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 facility failed to ensure an allegation of potential physical abuse for 1 of 1 resident (R2) who complained of rough care by staff, and an allegation of mental abuse for 1 of 1 resident (R3), who complained of being spoken to in an intimidating and frightening manner by staff were reported immediately but no later than 2 hours to the State Agency (SA). Findings include: R2's annual Minimum Data Set (MDS) dated 2/4/23, indicated R2 was severely cognitively impaired and required assistance of one staff for transfers and bed mobility.	F 609	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 the federal requirements of participation, this response and plan of correction constitute the centers allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. R2- Education was completed on		

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

PRINTED: 04/21/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2023
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - STILLWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082		
(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 609	Continued From page 2 R2's progress notes lacked mention of the incident. Review of the facility Suggestion or Concern form dated 9/25/22, indicated R2 told a nursing assistant (NA) early in the morning, (no time was indicated), NA-A was rough when NA-A helped R2 out of bed. The Minnesota Incident Report filed 9/26/22 at 12:56 p.m., by the facility social worker (SW)-A documented the incident occurred 9/25/22, at approximately 7:00 a.m., and was reported to the SA on 9/26/22, at 12:56 p.m., which was greater than 24 hours after the alleged incident. R3's discharge MDS dated 11/17/22, indicated R3 was cognitively intact. R3's progress notes lacked mention of the incident. Review of the facility Suggestion or Concern form dated 9/24/22, at 5:45 p.m., indicated NA-A was verbally aggressive towards R3, at the dinner table when R3 did not know NA-A's name and called NA-A, "That guy," and NA-A pulled his mask down and said to R3, "Don't ever call me 'Whatever his name is' again. Learn my name, I'm not a dog." The form further indicated NA-A was, "Angry-looking" and became, "Very hostile and dismissive." The Minnesota Incident Report filed on 9/26/22, at 12:36 p.m., by SW-A for that incident identified the incident occurred 9/24/22, at 5:45 p.m. When interviewed on 3/30/23, at 12:10 p.m. registered nurse (RN)-A stated she was required	F 609	4/3/2023 for RN-A by DNS on steps to take for reporting allegations of abuse or neglect including; ensuring the resident is safe and notifying the LNHA and/or the DNS immediately, the need to report all allegations of abuse or neglect within 2 hours and reviewed the abuse and neglect definitions. 2. All incident reports and grievances will be reviewed for potential abuse/neglect and to ensure all allegations of abuse and neglect were reported timely for the past month. 3. Continue to keep this current within the QAPI meeting agenda. RN-A was re-educated by DNS on 4/3/2023 on the requirements and timeframes for reporting abuse. RN-A was also re-educated on the definitions of abuse and neglect. The Social Services Coordinator was educated on 4/21/2023 by the LNHA on the reporting requirements and timeframes for alleged abuse and neglect and the 2 hour reporting requirement. 4. Audits will be completed by LNHA or designee, on any incident report or grievance forms, to ensure timely reporting was complete and appropriate. Audits will be completed weekly x4, then monthly x2. Results will be reported to the QAPI committee for review and further recommendations. 5. 4/23/2023		

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

PRINTED: 04/21/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2023
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - STILLWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082		
(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 609	Continued From page 3 to report alleged abuse as soon as the incident occurred to the facility leadership staff. RN-A stated she knew how to report abuse but didn't report the incident with R3 immediately because she was unsure if the incident qualified as abuse. RN-A stated she waited until she talked to the SW, who then reported the allegations. When interviewed on 3/30/23, at 2:33 p.m., the director of nursing (DON) stated SW-A who filed both Minnesota Incident Reports no longer worked at the facility. The DON further stated she was unsure why the reports were filed late, but acknowledged both reports should have been filed within two hours after the incidents. The Sanford Abuse and Neglect-Rehab/Skilled, Therapy and Rehab policy dated 10/13/22 indicated if there is an allegation of abuse, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. The Sanford Abuse Definitions-Rehab/Skilled and Therapy/ Rehab policy dated 12/27/22, indicated abuse included intimidation and verbal abuse. The Sanford Indicators of Abuse and Neglect-Rehab/Skilled and Therapy/Rehab policy dated 10/13/22, indicated behavior indicators of abuse included fear of person.	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 must:	F 610			4/21/23

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

PRINTED: 04/21/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2023	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - STILLWATER				STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082			
(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 4 §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 document review, the facility failed to thoroughly investigate physical abuse for 1 of 1 resident (R1 who alleged rough cares. In addition, the facility failed to thoroughly investigate an allegation of verbal and emotional abuse for 1 of 1 resident (R3) who alleged feeling afraid of and intimidated by a staff member. Findings include: R2's annual Minimum Data Set (MDS) dated 2/4/23, indicated R2 was severely cognitively impaired and required assistance of one staff for transfers and bed mobility. R2's progress notes lacked mention of the incident. Review of the facility Suggestion or Concern form dated 9/25/22, indicated R2 told a nursing assistant (NA) early in the morning, (no time was indicated), NA-A was rough when NA-A helped R2 out of bed.			F 610	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 the federal requirements of participation, this response and plan of correction constitute the centers allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. NA-A was suspended pending investigation and eventually terminated due to lack of cooperation during the investigation. 2. All incident reports and grievances will be reviewed for potential abuse/neglect and to ensure an investigation will be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2023
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - STILLWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082		
(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 5 The Minnesota Incident Report filed 9/26/22 at 12:56 p.m., by the facility social worker (SW)-A indicated R2 reported the NA, "Is rough getting him out of bed." R2's medical record lacked information about the incident. Upon review of the facility investigation file, the investigation lacked evidence of interviews with R2, the alleged perpetrator, the alleged witness, and other staff. R3's discharge MDS dated 11/17/22, indicated R3 was cognitively intact. R3's progress notes lacked mention of the incident. Review of the facility Suggestion or Concern form dated 9/24/22 at 5:45 p.m., indicated NA-A was verbally aggressive towards R3, at the dinner table when R3 did not know NA-A's name and called NA-A, "That guy," and NA-A pulled his mask down and said to R3, "Don't ever call me 'Whatever his name is' again. Learn my name, I'm not a dog." The Suggestion or Concern form further indicated NA-A was, "Angry-looking" and became, "Very hostile and dismissive." The Minnesota Incident Report filed 9/26/22 at 12:36 p.m., by the facility social worker (SW)-A indicated R3 reported NA-A was verbally aggressive, was very angry-looking, and became hostile and dismissive. The report further indicated registered nurse (RN)-A witnessed the incident.	F 610	initiated when required and to determine who will be interviewed, both staff and residents. Educate new Social Services Coordinator on 4/21/2023 on the interview process for alleged abuse, including physical, verbal and emotional. 3.Report to QAPI committee all incidents and grievances, including the status of the investigation process. 4. Audits will be completed by LNHA or designee, on incidents and grievances, to determine if an investigation has been completed, when required, with the appropriate persons. Audits will be completed weekly x4, then monthly x2. Results will be reported to the QAPI committee for review and further recommendations. 5. 4/23/2023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245207		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2023	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - STILLWATER				STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082			
(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 6 Upon review of the facility investigation file, the investigation lacked evidence of interviews with the alleged perpetrator, the alleged witness, and other staff. When interviewed on 3/30/23 at 12:10 p.m., RN-A stated she witnessed the incident with R3, and stated R2, "Would not make a report unless he actually felt like staff was rough," and acknowledged she had not been interviewed during the facility investigation for either incident. When interviewed on 3/30/23 at 11:15 a.m., the director of nursing (DON) stated she had no additional information about either facility investigation, but expected to see interviews with the witness, the employees involved, the residents involved, and anyone else identified as having potential for the same type of allegation. The Sanford Abuse and Neglect-Rehab/Skilled, Therapy and Rehab policy dated 10/13/22, indicated the facility would have evidence that all alleged or suspected violations are thoroughly investigated.			F 610			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2023
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - STILLWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 3/30/23, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was in compliance with the MN State Licensure The following complaints were reviewed during the survey:	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

04/21/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00903	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2023
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - STILLWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 1119 OWENS STREET NORTH STILLWATER, MN 55082		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 000	Continued From page 1 The following complaints were reviewed: H52079605C (MN92132 and MN92123) H52079939C (MN87143) H52079844C (MN87142) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			