MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Good Samaritan Society Waconia	H5234015	July 26, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
333 5th Street West	8:30 am - 3:30 pm	October 20, 2016
Facility City:	**Investigator's Name and Title:**	
Waconia	Rita Lucking, RN	

State:	ZIP:	County:
Minnesota	55387	Carver

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was neglected when the alleged perpetrator (AP) did not follow the care plan, and the the resident fell out of the EZ stand lift, sustained multiple fractures, and died a few days later.

- ☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- ☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of the evidence, neglect occurred when the alleged perpetrator (AP) transferred the resident alone, used the wrong type of lift, and the resident fell out of the EZ stand lift, was lowered to the floor and sustained fractures of her left hip and left upper arm.

The resident was dependent on staff to assist with activities of daily living. The care plan interventions to be used when transferring the resident during toileting were: two staff to assist, using a total lift (hydraulic powered sling lift) and large sling. The AP worked with the resident prior to the fall. The AP did not review the resident's care plan prior to transferring the resident. The AP used the EZ stand alone to transfer the resident from the wheelchair to a standing position. The resident suddenly lost strength in the left leg and wanted to sit down. The resident began to slip out of the EZ stand. The AP lowered the resident to the floor, and in the process, the resident fell on top of the AP. The resident complained of left leg pain after the fall. The on-call physician was contacted, and the resident was transferred to the hospital for further care. The resident sustained a left hip fracture and left upper arm fracture.

The resident's death certificate was reviewed and indicated the resident expired at the hospital. The immediate cause of death was listed as complications of left femur fracture.

When interviewed, the AP stated s/he made a mistake and although the resident's care plan was available, s/he did not review the care plan prior to the transfer. S/he stated a co-worker, employee (H), advised the AP to transfer the resident with the EZ stand lift. S/he stated s/he used the EZ stand lift and not the total lift

and attempted to transfer the resident to the commode alone without assistance from another staff. The AP stated s/he was provided re-education after the fall related to transfers and use of the care plan and was allowed to return to work on 7/11/16.

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility provided the AP with appropriate training related to transfers, lifts, and the use of the care plan during orientation. The facility also emphasized the need to review the care plan prior to transfers.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

The AP was placed on administrative leave following the incident and re-educated on 7/11/16 related to transfers and need to review the care plan prior to performing cares. In addition, all direct care staff were provided re-education related to transfers and use of the care plan/Kardex. Follow-up and monitoring of staff performance related to this incident will continue and be reviewed on an ongoing basis.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Treatment Sheets

☒ Physician Progress Notes
☒ Care Plan Records
☒ Skin Assessments
☒ Facility Incident Reports
☒ Laboratory and X-ray Reports
☒ ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

☒ Hospital Records ☒ Death Certificate

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.
☒ Facility Internal Investigation Reports
☒ Personnel Records/Background Check, etc.
☒ Facility In-service Records
☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Three

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A

Specify: Deceased

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: Deceased

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: 0

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Six

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Call Light
☒ Infection Control
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Facility Tour

Was any involved equipment inspected: ○ Yes ◉ No ○ N/A

Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Carver County Sheriff

Carver County Attorney

Waconia City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 07/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5234015. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement care plan interventions and operate equipment safely to minimize the risk of falls for 1 of 4 residents (R1) with a risk of falls. This resulted in actual harm when (R1) sustained a left hip fracture when being lowered to the floor from an EZ stand lift. Findings include: R1's medical record was reviewed. R1 had diagnoses including neoplasm of temporal lobe, obesity, encephalopathy, cerebral edema and left side flaccid hemiplegia related to a prior stroke. R1 was dependent on staff to assist with activities of daily living. The care plan interventions for	F 323		

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

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 323	Continued From page 1 toileting at the time of the incident were 2 assist with total lift and large sling to the commode or bed for use of the bed pan. The facility's incident report and internal investigation of the incident, dated 7/11/16, were reviewed. They indicated a nursing assistant failed to check R1's care plan/Kardex and on 7/9/16 transferred R1 to the commode using the EZ stand and the assist of one. R1's 12/10/15 toileting care plan revision stated the total lift and 2 staff should have been used with R1's transfer to the commode. Prior to the incident, the nursing assistant also asked a co-worker, who had not checked the care plan/Kardex, how to transfer R1 to the commode. The co-worker provided incorrect information which the nursing assistant followed related to the transfer. The nursing assistant transferred R1 from the wheelchair to standing position with the EZ stand, and R1 suddenly lost strength in her left leg, needed to sit down and began to slip out of the EZ stand. R1 was assisted to bed by three staff and a mechanical lift was used. R1 complained of left leg pain and the on-call physician was contacted, and x-rays were performed that revealed a hip fracture. R1 was transferred to the ER for further care per the on-call physician's order. R1 expired at the hospital on 7/13/16. The facility policy titled "Safe Resident Handling Program" dated April 2016, indicated a total lift (also referred to as a mechanical lift or full lift) is to be used with residents who cannot sit upright on the side of the bed, do not have weight-bearing ability on at least one leg and cannot pull themselves to a standing position requiring full weight-bearing support.	F 323		

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F 323	Continued From page 2 R1's death certificate was reviewed. It indicated R1 expired at the hospital on 7/13/16. The immediate cause of death was listed as complications of a left femur fracture that resulted from a 7/9/16 fall. When interviewed in person on 7/26/16, administrative nurse (B) stated nursing assistant (E) was responsible for R1's fall and resulting injury, and nursing assistant (E) admitted her error. Nursing assistant (E) failed to read R 1's Kardex prior to transferring R1. A full lift should have been used, and 2 staff should have assisted with R 1's transfer to the commode instead of one staff person. The Kardex clearly stated how R 1 was to be transferred. Nursing assistant (E) transferred R1 with the EZ stand in error and following the incorrect advice of nursing assistant (H) who also failed to check the Kardex related to R1's transfer. Both (E) and (H) had received appropriate training related to transfers and checking the Kardex prior to transferring a resident. Nursing assistant (E) was immediately disciplined and placed on administrative leave following the incident. Nursing assistant (E) returned to work on 7/11/16 and was provided re-education related to transfers and the need to review the Kardex prior to transfers. Nursing assistant (H) received a written warning and was provided re-education related to transfers and the need to review the Kardex prior to transfers. In addition, re-education related to transfers and review of the Kardex was provided to all direct care nursing staff following the 7/9/16 incident. Re-education, follow-up and monitoring of staff related to the incident will continue on an ongoing basis. When interviewed by phone on 7/28/16, LPN (F)	F 323		

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F 323	Continued From page 3 stated she was working with R 1 on the day of the incident. She verified that R 1 required an assist of 2 with toileting due to her left side weakness related to a prior stroke. She was summoned to R1's room by (H) and discovered nursing assistant (E) on the floor and R1 was on top of (E). R1 said her left leg became weak, and (E) lowered her to the floor. She stated the facility has provided re-education to staff related to lifts, transfer and use of the Kardex. When interviewed by phone on 7/28/16, nursing assistant (E) stated she was working with R1 on 7/9/16. She stated she had worked with R1 on prior occasions. The resident could not walk but could bear weight on her right leg. R1 asked to be put on the commode, and (E) asked nursing assistant (H) how to transfer R1. Nursing assistant (H) told her to use the EZ stand and said R1 was an assist of 1. Nursing assistant (E) did not check R1's care plan/Kardex and verify how R1 was to be transferred. During the transfer, R1 said she had to sit down, and (E) tried to put a chair under her but was unsuccessful. Nursing assistant (E) lowered R 1 to the floor, and in the process, R1 fell on top of (E). Nursing assistant (E) said she made a mistake and should have used a full lift and assist of 2 staff with R 1. R1 said her left leg hurt following her fall. After the incident, (E) checked the Kardex and noted the Kardex clearly stated how R 1 was to be transferred and the number of staff needed to assist with the transfer. Nursing assistant (E) was provided re-education related to transfers and the Kardex and was allowed to return to work on 7/11/16.	F 323		

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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: A complaint investigation was conducted to investigate complaint #H5234015. As a result, the following correction order is issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement care plan interventions and operate equipment safely to minimize the risk of falls for 1 of 4 residents (R1) with a risk of falls. This resulted in actual harm when (R1) sustained a left hip fracture when being lowered to the floor from an EZ stand lift. Findings include:	21810		

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21810	Continued From page 2 R1's medical record was reviewed. R1 had diagnoses including neoplasm of temporal lobe, obesity, encephalopathy, cerebral edema and left side flaccid hemiplegia related to a prior stroke. R1 was dependent on staff to assist with activities of daily living. The care plan interventions for toileting at the time of the incident were 2 assist with total lift and large sling to the commode or bed for use of the bed pan. The facility's incident report and internal investigation of the incident, dated 7/11/16, were reviewed. They indicated a nursing assistant failed to check R1's care plan/Kardex and on 7/9/16 transferred R1 to the commode using the EZ stand and the assist of one. R1's 12/10/15 toileting care plan revision stated the total lift and 2 staff should have been used with R 1's transfer to the commode. Prior to the incident, the nursing assistant also asked a co-worker, who had not checked the care plan/Kardex, how to transfer R1 to the commode. The co-worker provided incorrect information which the nursing assistant followed related to the transfer. The nursing assistant transferred R1 from the wheelchair to standing position with the EZ stand, and R1 suddenly lost strength in her left leg, needed to sit down and began to slip out of the EZ stand. R-1 was assisted to bed by three staff and a mechanical lift was used. R1 complained of left leg pain and the on-call physician was contacted, and x-rays were performed that revealed a hip fracture. R1 was transferred to the ER for further care per the on-call physician's order. R1 expired at the hospital on 7/13/16. The facility policy titled "Safe Resident Handling Program" dated April 2016, indicated a total lift (also referred to as a mechanical lift or full lift) is to be used with residents who cannot sit upright	21810		

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21810	Continued From page 3 on the side of the bed, do not have weight-bearing ability on at least one leg and cannot pull themselves to a standing position requiring full weight-bearing support. R 1's death certificate was reviewed. It indicated R1 expired at the hospital on 7/13/16. The immediate cause of death was listed as complications of a left femur fracture that resulted from a 7/9/16 fall. When interviewed in person on 7/26/16, administrative nurse (B) stated nursing assistant (E) was responsible for R 1's fall and resulting injury, and nursing assistant (E) admitted her error. Nursing assistant (E) failed to read R 1's Kardex prior to transferring R 1. A full lift should have been used, and 2 staff should have assisted with R 1's transfer to the commode instead of one staff person. The Kardex clearly stated how R 1 was to be transferred. Nursing assistant (E) transferred R 1 with the EZ stand in error and following the incorrect advice of nursing assistant (H) who also failed to check the Kardex related to R-1's transfer. Both (E) and (H) had received appropriate training related to transfers and checking the Kardex prior to transferring a resident. Nursing assistant (E) was immediately disciplined and placed on administrative leave following the incident. Nursing assistant (E) returned to work on 7/11/16 and was provided re-education related to transfers and the need to review the Kardex prior to transfers. Nursing assistant (H) received a written warning and was provided re-education related to transfers and the need to review the Kardex prior to transfers. In addition, re-education related to transfers and review of the Kardex was provided to all direct care nursing staff following the 7/9/16 incident. Re-education, follow-up and monitoring of staff	21810		

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21810	Continued From page 4 related to the incident will continue on an ongoing basis. When interviewed by phone on 7/28/16, LPN (F) stated she was working with R1 on the day of the incident. She verified that R 1 required an assist of 2 with toileting due to her left side weakness related to a prior stroke. She was summoned to R 1's room by (H) and discovered nursing assistant (E) on the floor and R1 was on top of (E). R 1 said her left leg became weak, and (E) lowered her to the floor. She stated the facility has provided re-education to staff related to lifts, transfer and use of the Kardex. When interviewed by phone on 7/28/16, nursing assistant (E) stated she was working with R1 on 7/9/16. She stated she had worked with R1 on prior occasions. The resident could not walk but could bear weight on her right leg. R1 asked to be put on the commode, and (E) asked nursing assistant (H) how to transfer R 1. Nursing assistant (H) told her to use the EZ stand and said R 1 was an assist of 1. Nursing assistant (E) did not check R 1's care plan/Kardex and verify how R1 was to be transferred. During the transfer, R1 said she had to sit down, and (E) tried to put a chair under her but was unsuccessful. Nursing assistant (E) lowered R 1 to the floor, and in the process, R 1 fell on top of (E). Nursing assistant (E) said she made a mistake and should have used a full lift and assist of 2 staff with R1. R1 said her left leg hurt following her fall. After the incident, (E) checked the Kardex and noted the Kardex clearly stated how R 1 was to be transferred and the number of staff needed to assist with the transfer. Nursing assistant (E) was provided re-education related to transfers and the Kardex and was allowed to return to work on 7/11/16.	21810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 07/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	**333 FIFTH STREET WEST WACONIA, MN 55387**

(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
21810	Continued From page 5 Time Period of Correction: 21 (Twenty-one) days.	21810		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245234		9/21/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 09/21/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00924 (Y1)	A. Building B. Wing (Y2)	9/21/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21810 Reg. # MN St. Statute 144.651 Subd. 6 LSC	Correction Completed 09/21/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO