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

Electronically delivered
November 15, 2024

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN  55387

RE: CCN: 245234
Cycle Start Date: August 15, 2024

Dear Administrator:

On October 16, 2024, we notified you a remedy was imposed. On November 14, 2024 the Minnesota Department of Health 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 November 6, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 15, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 16, 2024, 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 November 15, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 6, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

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

Electronically delivered

October 16, 2024

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN  55387

RE: CCN: 245234
Cycle Start Date: August 15, 2024

Dear Administrator:

On August 20, 2024, we informed you that we may impose enforcement remedies.

On October 1, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition.  The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 15, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 15, 2024.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 15, 2024.

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

**The CMS location may determine to impose other remedies such as a Civil Money Penalty.**

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 15, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Waconia And Westview Acre will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 15, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## 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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 15, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.**

## APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services**
**Departmental Appeals Board, MS 6132**
**Director, Civil Remedies Division**
**330 Independence Avenue, S.W.**
**Cohen Building – Room G-644**
**Washington, D.C. 20201**
**202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

## 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

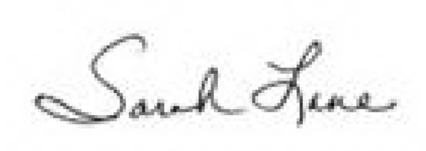
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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October 16, 2024

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN  55387

Re:  Event ID:  SAEH11

Dear Administrator:

The above facility survey was completed on October 1, 2024 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 feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308  Fax: 651-215-9697
Email: sarah.lane@state.mn.us

| 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 10/01/2024 |

| 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 |

| (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<br><br>On 9/30/24 to 10/1/24, 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.<br><br>The following complaints were reviewed<br>H52348892C (MN00106939/MN00107083/MN00107027)<br>H52347841C (MN00106269)<br>H52348405C (MN00106712)<br>with a deficiency cited at F610, F684.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. | F 000 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation<br>CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the | F 610 | | 11/6/24 |

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

Electronically Signed | 10/24/2024

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

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| F 610 | Continued From page 1<br>investigation is in progress.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to complete a thorough investigation for 2 of 3 residents (R5, R9) who reported concerns related to quality of care.<br><br>Findings include:<br><br>Facility investigation indicated the director of nursing (DON) was notified via email on 9/16/24 at 4:24 p.m., from administrative assistant (AA)-D the facility had "two bad apples" working there. The document included handwritten notes dated 9/18/24 at 11:50 a.m., listing licensed practical nurse (LPN)-B and nursing assistant (NA)-A had not completed nightly rounds and refused to complete requested cares stating the next shift could complete them. Further, the document indicated R5's name dated 9/18/24 at 12:10 p.m. Information listed included LPN-B and NA-A had laughed when he reported he had chest pain, had not followed up on the report with any assessment or monitoring, and they had spoke to him and other residents in a condescending or argumentative way. Facility investigation lacked evidence other residents and other staff were interviewed about the identified concerns.<br><br>Facility schedules indicated LPN-B worked | F 610 | 1. The investigation regarding R5 and R9 was completed on 10-7-24. The Director of nurses investigation included interviewing R5 and R9 on the cares they receive and interviewing staff providing the cares to them, including the two mentioned by the residents. Also, the Senior Director provided training to facility leadership by 10-25-24, regarding facility s Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and on location s internal vulnerable adult investigation checklist guide.<br><br>2. All residents have a potential to be affected by this practice. The DNS interviewed other random residents to ascertain the care they are receiving meets the quality standards. Center reviewed all pending grievances and concerns to ensure comprehensive investigation was done to all residents. All members of the leadership team received education by 10-25-24 regarding immediate investigations of Abuse, Neglect, Mistreatment and Misappropriation of Resident Property and on location s internal vulnerable adult | |

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| F 610 | Continued From page 2<br>9/17/24, 9/20/24, 9/22/24, 9/23/24, 9/24/24, 9/27/24, 9/28/24, 9/30/24 and NA-A worked 9/17/24, 9/18/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24, 9/23/24, 9/24/24, 9/26/24, 9/27/24, 9/30/24.<br><br>During an interview on 10/1/24 at 1:15 p.m., DON stated LPN-B and NA-A frequently worked the same shift on the same unit. She stated no changes to the schedule had been made since the report on 9/16/24. The DON stated she had not spoken with LPN-B or NA-A in person nor by phone 9/30/24. However, she had left messages requesting they speak with her. DON stated she had not attempted to speak with either staff at the facility during their scheduled shifts. Further, the DON had not spoken with any additional residents to inquire about quality of care received, nor other staff members to obtain reports on care provided by LPN-B or NA-A since the report filed on 9/16/24. The DON stated she spoke with human resources and was instructed to complete a written warning to put in LPN-B and NA-A's employee files.<br><br>During an interview on 10/1/24 at 3:01 p.m., DON stated she had only spoken with R5 and R9 regarding cares received because R9 told her many residents were not cognitively intact and therefore could not report concerns. The DON again confirmed she had not reviewed charting or spoken with other residents or staff regarding concerns. The DON stated she had not followed up with either R5 nor R9 but planned to next week. The DON stated it had not occurred to her to interview other residents or staff as part of the investigation.<br><br>During an interview on 10/1/24 at 3:32 p.m., | F 610 | investigation checklist guide. Education will be completed by the Administrator or Senior Director.<br><br>3.To ensure systemic changes are sustained, education was completed by DNS/designee to all staff members regarding facility's abuse and neglect policy, which covers investigations and reporting of these instances. Also, all leadership team provided education by DNS/designee to on immediate and comprehensive investigations of all grievances and concerns per policy. All vulnerable adult internal guide/checklists and investigations will be reviewed at the locations interdisciplinary team meeting weekly.<br><br>4. To assure compliance, the facility Interdisciplinary Team will review all verbal and written grievances for thorough investigation and reporting requirements. All vulnerable adult reports, for the next 8 weeks or until substantial compliance can be determined, will be reviewed by the Administrator or designee to ensure a proper investigation and documentation of investigation did occur. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained.<br><br>5. Date of correction 11-6-24. | |

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| F 610 | Continued From page 3<br>facility administrator stated he expected any complaint from a resident regarding quality of care was followed up on "as soon as possible." His expected time frame for "as soon as possible" was dependent on the complaint or concern brought forward. | F 610 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to consistently administer medication in the time frame allotted (one hour before and after assigned time) for 1 of 2 residents, (R2), reviewed for receiving a combination medication used for treatment of Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination).<br><br>Findings include:<br><br>R2's Admission Minimum Data Set (MDS) indicated R2 was cognitively intact and was able to communicate needs and identify preferences. The MDS identified R2 had a medically complex condition. R2's MDS identified medical | F 684 | 1. Immediate education was provided to the nurses administering medications to R2 to adhere to the allotted time frames per provider orders. All nurses and TMA will be educated regarding med administration time frames as allotted and will be completed by 10/25/24.<br>2. All residents have a potential to be affected by this practice. As a result, their electronic MAR were reviewed to ensure that all residents medications are administered per the allotted time frame by providers. No concern was identified during the audit<br>3. To ensure systemic changes are sustained, education will be completed to all Nurses and TMAs by DNS/designee regarding medication administration | 11/6/24 |

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| F 684 | Continued From page 4<br>diagnoses, which included arthritis due to other bacteria, sepsis (infection of the bloodstream) due to methicillin susceptible staphylococcus aureus (MRSA-a type of infection which is resistant to many antibiotics), a cerebrovascular accident (CVA-stroke), and Parkinson's disease.<br><br>A review of R2's medication administration record for September of 2024 indicated R2 was to receive Sinemet (Carbidopa-Levodopa-a medication used in management of Parkinson's disease) five times a day. The time of medication administration identified on the medication record correlated with the times the medication had been administered to R2 in the hospital.<br><br>During interview on 9/30/24, at 10:23 a.m. family member/friend (FM-A) identified concerns regarding the administration times of R2's medication. FM-A stated she had specific directions as to how the medications were to be taken, however, R2 had reported to FM-A the medications were not given within the allotted time frames.<br><br>A review of the medication administration record (MAR) was completed for the month of September 2024, which identified medications were to be given at 8:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m. and 10:00 p.m.. The MAR did not identify the exact times the medications were administered. A request was made from the director of nursing (DON) for documentation to reflect actual time the medications were given.<br><br>On 9/30/24, at approximately 1:00 p.m. the MAR information provided by the DON was received. A review of the MAR screen shots of the information identified nine instances in the dates | F 684 | guidelines and best practices. DNS will also review our policy regarding medication administration guidelines and best practices to all nurses and TMA. Education and policy review will be completed on 10-25-24.<br>4. To assure compliance, the facility will conduct random eMAR audits of 8 residents per week to make sure that they are given medications in the allotted time per provider orders. The DNS or designee will be responsible to monitor the audits of the electronic MARS weekly. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained.<br>5. Date of correction 11-6-24. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 684 | Continued From page 5 | F 684 | | |

provided from 9/5/24 through 9/17/24 when the time frame was greater than one hour before or after the designated time. The DON stated medications were to be given within one hour before, or after, the designated time to be considered within the required time frame. The DON stated medications were to be given within the time frame as ordered to assure proper spacing of the dosing, especially when the medication is ordered multiple times per day.

During interview on 10/1/24, at 10:39 a.m., registered nurse (RN-A), clinical manager, stated upon admission, when a resident was receiving frequently dosed, time sensitive medicines, she reviewed the medical records from the hospital, or admitting organization, and interviewed the resident to assure this was the time the resident had previously taken the medication at home to assure it was given with the same spacing. RN-A stated medications were to be administered within one hour before, or after, the designated time to meet the time frame requirements. RN-A reviewed the times of actual medication administration time frame for the medication. The following concerns were identified with administration, as denoted by the dates:

On 9/2/24, the 6:00 p.m. medication was given at 7:36 p.m (1 hour and 36 minutes beyond the time scheduled-36 minutes outside of the parameters of allowed medication administration time).

On 9/3/24, the 8:00 a.m. medication was given at 9:44 a.m. (1 hour and 44 minutes beyond the time-44 minutes outside of the parameters of allowed medication administration time).

On 9/4/24, the 8:00 a.m. medication was given at 9:29 a.m. (1 hour and 29 minutes beyond

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| | 245234 | A. BUILDING _____ B. WING _____ | C 10/01/2024 |

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

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the time-29 minutes outside of the parameters of allowed medication administration time).

On 9/5/24, the 6:00 p.m. medication was given at 7:06 p.m (1 hour and 6 minutes beyond the time-6 minutes outside of the parameters of of allowed medication administration time).

On 9/6/24, the 12:00 p.m. medication was given at 13:08 p.m (1 hour and 8 minutes beyond the time-8 minutes outside of the parameters of allowed medication administration time).

On 9/8/24, the 8:00 a.m. medication was given at 10:29 a.m. (2 hours and 29 minutes beyond the time-1 hour and 29 minutes outside of the allowed medication administration time). The previous dose had been given at 11:07 p.m. on 9/7/24 (this is a period of 11 hours and 22 minutes). The next dose of the day was given at 1:17 p.m. for the 12:00 p.m. dose. This is 17 minutes beyond the parameters allowed for medication administration. This was also a spacing of 2 hours and 48 minutes space, versus the 4 hours spacing scheduled. The subsequent dose was ordered for 3:00 p.m., and was administered at 2:47 p.m. This was a spacing of 1.5 hours instead of the 3 hours spacing scheduled.

On 9/9/24, RN-A stated the dosing of medications were delayed related to R2 being in the ER, and medications were administered upon her return.

On 9/11/24, the 8:00 a.m. medication was given at 9:36 a.m. (1 hour and 36 minutes beyond the time-36 minutes outside of the parameters of allowed medication administration time).

On 9/12/24, the 8:00 a.m. medication was given at 9:21 a.m. (1 hour and 21 minutes beyond the time-21 minutes outside of the parameters of medication time).

On 9/13/24, the 6:00 p.m. medication was set

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| F 684 | Continued From page 7<br>up 5:41 p.m., however was signed out at 7:41 p.m. (1 hour and 41 minutes beyond the time-41 minutes outside of of the allowed medication administration time).<br>On 9/14/24, the 8:00 a.m. medication was given at 9:49 a.m. (1 hour and 49 minutes beyond the time-49 minutes outside of the parameters of of allowed medication administration time). Following the review of the times noted above, RN-A stated she noted the majority of the areas of concerns are related to the morning medication pass at 8:00 a.m.. RN-A stated R2 had identified upon admission she experienced increased stiffness and pain when her meds were not given in a timely fashion. RN-A stated one the primary concerns would be the potential side effects experienced related to not receiving her medications on time, especially because this was definitely a time sensitive medication. In addition to R2, RN-A identified other residents would be potentially impacted with this problem as well. RN-A stated timed pain medications, thyroid medications, anticoagulants, and medications given more than daily were the ones she was most concerned about.<br><br>On 10/1/24, at 12:33 p.m. the consultant pharmacist (CP-A), was contacted regarding the delayed medication administration times. CP-A stated the medication had a short half-life (the time it takes a medication in your body for the active substance in a medication to reduce by half), and added the medication reached it's peak effectiveness in 30 minutes. CP-A stated delayed administration of this medications had the potential for the resident to experience side effects.<br><br>The facility policy, Medication: Administration | F 684 | | |

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| F 684 | Continued From page 8<br>Including Scheduling, reviewed/revised 3/29/23, identified the purpose of the policy included administration of medications correctly and in a timely manner, as well as to schedule medications effectively. Upon review of the policy, under the section labeled "Procedure", the staff were directed to: Administer medications within at least 60 minutes on each side of ordered time. | F 684 | | |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On 9/30/24 to 10/1/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders | 2 000 | | |

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| 2 000 | Continued From page 1<br>and identify the date when they will be completed.<br><br>The following complaints were reviewed<br>H52348892C (MN00106939/MN00107083/MN00107027)<br>H52347841C (MN00106269)<br>H52348405C (MN00106712)<br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is | 2 000 | | |

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| 2 000 | Continued From page 2<br>not required at the bottom of the first page of state form.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |