Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 13, 2024

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: November 26, 2023

Dear Administrator:

On December 28, 2023, we notified you a remedy was imposed. On February 12, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 12, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 26, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 28, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 26, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 12, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2023

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

RE: CCN: 245279
Cycle Start Date: November 26, 2023

Dear Administrator:

On November 26, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 February 26, 2024 (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 May 26, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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December 12, 2023

Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway Avenue
Robbinsdale, MN 55422

Re: Event ID: WOQM11

Dear Administrator:

The above facility survey was completed on November 26, 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 feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 11/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

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F 000	INITIAL COMMENTS On 11/20/23 through 11/22/23 and 11/26/23, a standard abbreviated survey was conducted at your facility. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52797212C (MN00098592) with a deficiency cited at F600. 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		11/26/23

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

Electronically Signed | 12/13/2023

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

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F 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a resident was free and protected from ongoing verbal and physical abuse by a nursing assistant (NA)-A, for 1 of 1 resident (R1) who verbalized staff abuse. Findings include: A Facility Reported Incident (FRI) submitted to the State Agency (SA) dated 11/16/23 at 1:04 p.m., included an allegation of emotional or mental abuse that occurred on 11/16/23 at 11:15 a.m. The report indicated staff overheard NA-A yell at R1 while providing cares. NA-A said "is that what you want?" and "this is how it's going to be" in a raised voice before leaving the room and slamming the door. In a common space NA-A yelled "she just kicked me in the head" and NA-A asked about R1's discharge plan. An email to human relations specialist (HRS) from director of nursing (DON) dated 11/16/23, at 1:22 p.m. indicated nursing assistant (NA)-A was suspended pending further investigation of an allegation of verbal abuse. An email to human resource specialist (HRS) and administrator dated 11/17/23, at 4:06 p.m. indicated social worker (SW), therapy, and activity assistant all heard NA-A yelling. The email indicated a visitor that was in another resident room had also heard the yelling and came out of the room to see if anything was, "wrong". NA-A	F 600	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. NA-A was suspended pending investigation at time of incident. NA-A was terminated and did not return to work following the incident. R1 had no further incidents and continued with discharge plan. 2. All residents in the facility have the potential to be affected by the deficient practice. As a result, all staff have been trained on abuse and neglect per organization's policy. Also, specific NA-A is no longer employed at the center. 3. To ensure systemic changes are sustained, Re-education for all facility staff was completed on Good Samaritan Society's policy and procedure for abuse	

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F 600	Continued From page 2 was overheard yelling, "Is that what you want?" and "Then that's how you're going to be," and slammed the door. R1's care plan identiifed, "Two people to assist resident, as she can be combative with cares, is confused. She was not following the care plan, and she was yelling at the resident according to 3 witnesses. Resident (R1) was witnessed crying after this episode but did not remember it the next day as she was cognitively impaired. The email also included statement from the therapist which included, I was in the hallway when it happened. [R1] had fallen in the bathroom and [activities assistant] found her and went to the nurse. Immediately [NA-A] said I can't do this anymore, I'm sick of her falling, I don't want to keep picking her up. [R1] was screaming when [NA-A] approached her. She said you're hurting my arm [NA-A] screamed at [R1] You can't do that, you can't hit me in my face. [NA-A] stormed out of the room and yelled I'm being hit, I can't do this alone. The nurse went in and helped get her up. [NA-A] went in and slammed the door shut. I could hear [R1] screaming and crying. Nurse left to get vitals, [NA-A] went over and slammed the door shut. It was just [R1] and [NA-A] in the room. You could hear [R1] crying. After the incident [NA-A] brought [R1] to the dining room. [NA-A] yelled she keeps hitting me, she shouldn't be here anymore, [NA-A] yelled at [SW] when are you getting her out of here, she can't be here anymore." There was no indication, the facility had interviewed R1 about the incident. R1's face sheet identified R1 had diagnoses that included spinal stenosis, type 2 diabetes, post traumatic stress disorder (PTSD), major depressive disorder, borderline personality disorders, other specified behavioral and	F 600	and neglect. Re-education included a return on demonstration competency and has an emphasis on intervening and taking measures to protect the resident when safe to do so. 4. Routine audits of reporting, investigating, and correcting allegations of abuse or the witness of suspected abuse will be completed x6/week. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The Administrator and/or designee will be responsible for correction of deficiency by 11/26/2023.	

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F 600	Continued From page 3 emotional disorders. R1's significant change Minimum Data Set (MDS) 10/26/23 identified R1 had severe cognitive impairment. The MDS identified R1's mood interview should not be completed because R1 was rarely/never understood. Staff assessed R1 to have a mood score of zero indicating no depressive symptoms, however, the MDS identified R1 had physical and verbal behaviors directed towards others daily and other daily behavioral symptoms not redirected toward others. R1 also had delirium signs and symptoms of inattention, disorganized thinking, and altered level of consciousness that comes ad goes and changes in severity. R1 was dependent on staff for toileting, lower body dressing, and needed partial to moderate help for bathing, upper body dressing. Additionally R1 required supervision to touch, help as needed for personal hygiene. R1's care plan dated initiated on 9/8/23, did not identify a plan of care that identified R1's vulnerabilities and/or risk factors for abuse. R1's cognition care plan dated, 9/11/23, identified R1 had impaired cognitive function/dementia or impaired thought process related to poor memory, post traumatic stress disorder, attention deficit hyperactivity disorder, anxiety, borderline personality, and history of trauma of sexual abuse. Corresponding intervention included two care givers for cares as able. R1's mood/behavior care plan dated 9/19/22, identified R1 had a mood problem of violence; will hit and verbally swears at staff. Interventions directed staff to educate resident/family regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance. Consult with pharmacy, provider to	F 600		

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F 600	Continued From page 4 consider dose reduction when clinically appropriate. R1's progress notes reviewed for 11/16/23, did not identify R1 sustained verbal abuse and/or rough treatment. The only progress note documented on 11/16/23 was authored by the SW at 2:27 p.m. "[SW] heard screaming from the resident room. The [NA] came out and stated that the resident kicked her in the head during her care." During an observation and interview on 11/21/23 at 12:13 p.m., R1 stated she has fallen a lot. R1 explained there was one girl who had gotten rough with her but she was now gone. The girl wanted her to do something she could not do, the girl hit R1, so R1 hit her back. R1 told the girl "under no circumstances can you hit me and not expect me to hit back." As R1 explained her account, R1's voice/tone sounded angry/upset/irritated, but was not tearful. R1 stated all other staff have treated her nicely. R1 did not tell anyone about what the girl did, she just punched her back. R1 reported no staff including the social worker had not talked to her about the incident. During an interview on 11/20/23, at 4:12 p.m. registered nurse (RN)-B stated NA-A had difficulty being with residents in general. NA-A would question residents asking them such things as "you were doing it yesterday, so why aren't you doing it today?" RN-B stated NA-A didn't understand dementia. NA-A had a high pitched voice and the tone of her voice would come across as rude. NA-A was fine with the residents as long as the residents were doing what NA-A felt they were supposed to be doing, but if not	F 600		

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F 600	Continued From page 5	F 600		

NA-A had inappropriate reactions to them. RN-B could see NA-A made some of the residents upset, but those resident never came and said anything after interacting with NA-A.

During an interview on 11/22/23, at 9:57 a.m. supervisor of therapy (SOT) stated on 11/16/23 she was in the hallway where R1 resided when activities assistant (AA) had come out of R1's room looking for a nurse after R1 had fallen. SOT remembered overhearing NA-A saying, "I can't keep doing this." R1 was heard screaming, "that hurts my arm." NA-A was in R1's room by herself, NA-A was loudly yelling, "Stop hitting me." NA-A came out of R1's room and slammed the door shut. NA-A walked over to the nurse and said, "I need your help, I need you to come in here she is hitting me." Registered nurse (RN)-A and NA-A entered the room together bringing with them the full body lift. NA-A "slammed the door again" behind them. Soon after that, NA-B then entered the room. SOT stated she could hear R1 crying and saying, "OW!" NA-A could be heard saying loudly "when is she getting out?" "She needs to go!" SOT and SW were in the hallway together as they had scheduled care conferences that day. SW had informed SOT she was going to report NA-A to the DON related to this incident. At the time, SOT had felt R1 was safe because a nurse had gone in to help. SOT felt NA-A was inappropriate with R1 and it seemed R1 was, "being attacked." "Things were happening so fast but in retrospect it would have been a smart decision to remove NA-A, but she was the only NA on the floor at the time and the nurses needed the help to get R1 off the floor."

During an interview on 11/21/23 at 1:45 p.m. social worker (SW) indicated she was present the

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F 600	Continued From page 6 day of the incident that involved R1 and NA-A, however, could not recall the date and time. SW knew the incident happened before she had a care conference, so guessed it was between 10:30 a.m. and 11:00 a.m. SW recalled she was in the hallway when she heard screaming coming from the closed door of R1's room. SW heard NA-A say, "if that is what you want, that is how it will be." NA-A then came out of the room and asked when R1 would be discharged. RN-A then went in to help NA-A. RN-A came out of R1's room and little while later. NA-A then came out of the room and said, "I can't do this anymore" and returned into R1's room slamming the door behind her. NA-A was alone in the room with R1, RN-A was going in and out of R1's room. SW indicated when NA-B came back from break she told her to go in and help NA-A. SW stated she was concerned with the way NA-A had slammed the door and the way NA-A stated, "she couldn't do this anymore." SW indicated after an abuse incident the resident was supposed to be checked on right away. SW had not done that until after the care conference when she found R1 in the common area and talked to her; R1 seemed calmer. SW explained she felt if she had talked to NA-A during the incident or taken her aside at the time, it would have escalated the problem. NA-A "was a loud person but that day was just different, I should have stepped in and should have gone in the room to see what was going on in the room." "I didn't think it was that bad, but in hindsight, I should have gone in there." The SW did not report the incident to the DON immediately. During and interview on 11/21/23, at 4:11 p.m. RN-A indicated on 11/16/23 she believed R1 had fallen from her wheelchair in her room when she	F 600		

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F 600	Continued From page 7 heard NA-A yelling at R1 and NA-A "come storming out of the [R1's] room." RN-A stated she and NA-A transferred R1 from the floor. NA-A was telling R1 to stop crying and acting like a baby. NA-A was being verbally aggressive and at one point NA-A pushed R1 too quickly. RN-A stated she told NA-A to calm down and was trying to reassure R1. R1 was crying and scared but NA-B and RN-A were able to calm her down after NA-A left. R1 was anxious related to NA-A. RN-A didn't feel comfortable with how NA-A was speaking with R1 and would say she was being verbally abusive. RN-A explained she did not ask NA-A to leave the room because she was intimidating and felt NA-A would have responded badly towards her. RN-A stated if she ever witnessed abuse, she would let someone know like the social worker or the DON. RN-A did not think the facility had provided any kind of abuse training since she had started working at the facility. During an interview on 11/21/23 at 2:28 p.m., NA-B indicated she worked on 11/16/23, and was on break at the start of the incident. NA-B remembered NA-A had went into R1's room by herself and heard R1 yelling for help. NA-B went into R1's room and helped NA-A get R1 off the floor with a sling and the lift. NA-B stated NA-A "just grabbed the sling with [R1] on it and turned her tough" NA-A said loudly,"I can't deal with this""and was rough and swung R1 on the floor like that." NA-B did not like what she was seeing, she felt embarrassed for the way NA-A was treating R1. "NA-A could have waited for help instead of just grabbing R1 and swinging her like that." NA-B explained 'Even an animal you don't treat like that." NA-B reported staff were supposed to report abuse. NA-B did not intervene	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	C 11/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

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F 600	Continued From page 8 during the incident and wanted to talk to NA-A after the incident, not in the whole group. NA-B indicated had she had the opportunity to speak with NA-A after the incident NA-B would have "told her to not do that next time, it wasn't right." NA-B stated, R1 did cry and was upset by the actions. NA-A did not respond to R1's crying, "she [NA-A] didn't realize she had done anything wrong." Later in the day NA-B saw NA-A "get walked out." of the facility. During an interview on 11/20/23, at 3:52 p.m. clinical nurse manager (CM)-A stated, "She [NA-B] was removed Thursday [11/16/23] around 12:45 p.m. and 1:00 p.m." An email to (HRS) from director of nursing (DON) dated 11/16/23, at 1:22 p.m. indicated nursing assistant (NA)-A was suspended pending further investigation of an allegation of verbal abuse. During an interview on 11/22/23 at 8:17 a.m., NA-A stated she was charting on the day of the incident and heard therapy telling the nurse R1 had fallen. NA-A explained she went into R1's room by herself and R1 was swinging at her. NA-A told R1 to stop trying to hit her and R1 kicked NA-A in the face. NA-A asked R1 why she kicked her in the face. NA-A reported the social worker, nurse, and 3 therapy ladies were in the hall and none came to help her, so felt like they did not care. NA-A heard RN-A say, "She was over it." NA-A explained she had not slammed the door, but had asked the social worker "why is R1 still here?" NA-A has told R1 "to stop crying all the time" and has called R1 "baby and aunty" but it was to make R1 happy. NA-A never said, "I can't do this anymore or I have had it," however, had	F 600		

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F 600	Continued From page 9 gone to the administrator and stated she needed more help. NA-A stated, "sometimes the job can be very overwhelming." During an interview on 11/22/23, at 7:51 a.m. NA-C stated, if she witnessed a staff member being verbally abusive with a resident, she would not stop it in a public setting. NA-C was concerned if she said something it may lead to further aggression. During and interview on 11/21/23 at 3:12 p.m., director of nursing (DON) stated SW had come to her and told her about a situation with NA-A yelling at a resident behind closed doors. SW had heard "Is that what you want, that is how your going to be," and NA-A came out of R1's room and slammed the door. DON believed SW had told her right away and a nurse had been sent in to help, however was not aware SW first went to the care conference before reporting the incident. DON stated she would have expected the nurse to stop any abuse if it was happening. DON stated the administrator and nurse manager pulled NA-A off the floor and met in the conference room after they were notified. When they interviewed NA-A, NA-A endorsed her voice could get loud, it could sound like she was yelling, but she was not yelling at R1. DON stated all staff were not educated after the event as she felt it was an isolated event. A policy titled, Abuse and Neglect-Rehab/Skilled, Therapy and Rehab with a revision date of 7/6/23 indicated it is in place to ensure that all employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations, to ensure the location has an effective system in place that prevents	F 600		

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F 600	Continued From page 10 mistreatment, neglect, exploitation and abuse of residents, to ensure that residents are not subjected to abuse by anyone. Alleged or suspected violations involving any mistreatment, neglect, exploitation, or abuse, will be reported immediately to the administrator or designated individuals by the administrator to: 1. Intervene in any situation in order to protect residents. 2. Remove any individual from the location if necessary for the protection of the residents or employee. 3. Call local law enforcement for assistance with interventions necessary for the protection of the resident or employee. 4. Call 911 for any type of emergency assistance. Procedure: If an employee receives an allegation of abuse, neglect, exploitation, or misappropriation of resident property or witnesses suspected abuse, neglect or misappropriation of resident property, the employee will take measures to protect the resident, provided the safety of the employee is not jeopardized.	F 600		

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	00890	A. BUILDING: _____ B. WING _____	C 11/26/2023

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GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY AVENUE ROBBINSDALE, MN 55422

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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: On 11/20/23 through 11/22/23 and 11/26/23 a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed:	2 000		

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2 000	Continued From page 1 H52797212C (MN00098592). No licensing orders were issued. 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		