

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 10, 2021

Administrator Good Samaritan Society - St James 1000 South Second Street St James, MN 56081

RE: CCN: 245593

Cycle Start Date: November 23, 2021

Dear Administrator:

On November 23, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

Good Samaritan Society - St James December 10, 2021 Page 2

- 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" tag), i.e., the plan of correction should be directed to:

> Susie Haben, Rapid Response Licensing and Certification Program **Health Regulation Division** Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557

Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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 23, 2022 (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).

Good Samaritan Society - St James December 10, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by May 23, 2022 (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, Health Program Representative Senior

Program Assurance | Licensing and Certification

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:

PRINTED: 12/27/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

		245593	B. WING		C
NAME OF F	PROVIDER OR SUPPLIER	240000	5:	STREET ADDRESS, CITY, STATE, ZIP CODE	11/23/2021
				1000 SOUTH SECOND STREET	
GOOD S	AMARITAN SOCIETY	- ST JAMES		ST JAMES, MN 56081	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 000	INITIAL COMMENT	ΓS	F 00	0	
	abbreviated survey Your facility was fou with the requiremen	1/23/21, a standard was conducted at your facility. und to be NOT in compliance ats of 42 CFR 483, Subpart B, ong Term Care Facilities.			
	The following comp SUBSTANTIATED:	laint was found to be			
	F677. H5593033C (MN78 H5593034C (MN78 (MN78694), howeve	1588), with a deficiency cited at 1641 and MN78650), 1586) and H5593037C er, NO deficiencies were cited 1586 by the facility prior to			
	as your allegation on Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.			
	onsite revisit of you validate that substa regulations has bee ADL Care Provided	for Dependent Residents	F 67	7	12/24/21
3S=D	out activities of daily services to maintain personal and oral h	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and			
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE
Electron	ically Signed				12/17/2021

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245593	B. WING			C 23/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/2	20/2021
				1000 SOUTH SECOND STREET		
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F 677	5 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -		F 67	7		
	by: Based on observation, interview and document reviewed, the facility failed to provide activities of daily living (ADL), specifically personal hygiene of regular bathing for 1 of 3 residents (R4) who were dependent upon staff for personal cares. Findings include: R4's Face Sheet printed 11/23/21, indicated he was admitted to the facility on 8/19/21. R4's primary admitting diagnoses dated 8/19/21, include cognitive communication disorder (difficulty in verbally communicating), Myasthenia			F677 ADL Care Provided for Dep Residents Preparation and execution of this response and plan of correction of constitute an admission or agreet the provider of the truth of the fact alleged or conclusions set forth in statement of deficiencies. The plate correction is prepared and/or exested by the provisions of federal and state law the purposes of any allegation that center is not in substantial complete.	loes not ment by ts the an of cuted e v. For at the	
	Gravis (neurologic of limbs and proble lumbar vertebra, a R4's Care Plan las directed that R4 ha bowel related to im	al disease-causing weakness ems with speaking), collapsed nd urinary incontinence. It revision dated 9/28/21, ad frequent incontinence of a paired mobility and required		with federal requirements of partithis response and plan of correct constitutes the center's allegation compliance in accordance with se 7305 of the State Operations Man	cipation, on of ection nual.	
	communication pro Gravis and a heari neurological status evidenced by seve alteration in activity speech evidenced understanding R4' breath related to M decreased energy, impairment; and he performance defice and requires limite bathing/showering	Insfers and toileting; had a soblem related to Myasthenia ing deficit; has an alteration in a related to Myasthenia Gravis are muscle weakness; had y involvement related to unclear by staff having difficulty is requests; has shortness of Myasthenia Gravis evidenced by a fatigue, and musculoskeletal and an ADL self-care it related to Myasthenia Gravis it related to myasthenia Grav		Resident R4's care plan was reviand his preferences for bathing retwo times per week. Resident R4 given a bath on 11/21/2021. All residents were reviewed to enbathing and documentation is in perfect to all CN working at Good Samaritan Society James by the DNS on 12/15/2021 were re-educated on how to chart tasks in POC, which is part of PCE ducation also included that all certain to be completed prior to leaving the for the day. The bath schedule were reviewed and updated to level the	eflected was sure place. As ety – St. I. CNA's t bathing C. narting is ne shift as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUC			E SURVEY PLETED
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F 677	on the brief interviassessment indicand required exte and personal hyging and required exte and personal hyging the facility Section 11/23/21, had R4 during the Sunday during the Gay shifthe schedule direct talking to the case. The facility Docum October and Nove 11/23/21, docume whirlpool baths dureceived four: 10/03/21 - no bath 10/10/21 - no bath 10/10/21 - no bath 10/10/21 - no bath 10/27/21 - no bath 10/27/21 - no bath 10/31/21 - no bath 10/31/21 - no bath 11/03/21 - whirlpo 11/07/21 - no bath 11/03/21 - no bath 11/07/21 - no bath 11/10/21 - no bath 11/	iew of mental status ating R4 as cognitively intact insive assistance with toileting ene. In #1 Bath Schedule copied scheduled for a whirlpool bath yevening shift and Wednesday ft. Directions at the bottom of cted, "do not change without emanager." Intentation Survey Report for ember 2021, printed on ented R4 was to receive fifteen uring 10/01/21 - 11/23/21 but In the collection of th	F	load betw according The C NA increase ensure ba the reside for bathin Audits wil is done po These au other rand monthly X monthly X	ween each shift and h g to resident's prefere A schedule has been C NA hours during pe athing is completed a ent's care planned pre	adjusted to eak times to according to eferences sure bathing approaches. R4 and 3 y X 4 then aken to the	
	documented in the summary reportin her that R4 smelle	te practitioner (NP)-A e medical appointment g the family sent a message to ed of urine and was concerned t providing peri-care.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ST JAMES		STREET ADDRESS, CITY, STATE, ZIP C 1000 SOUTH SECOND STREET ST JAMES, MN 56081		
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F 677	R4's wheelchair seathe cushion smelling that she made the formulation of the cushion smelling that she made the formulation of that he was not get that he liked whirlow to have the two whis set-up during his achim feel sad and not a bath for extended yes that he has ask bath, but they did not be composed on the cushing an interview power of attorney (I her that he was not POA reported this to went to staff and disbath R4. During an interview nursing assistant (Not doing the baths, but them. Instead, staff washing the resider enough time with the doubt and interview registered nurse (Rare to follow the baths. RN-A further staff and using a loss only indicate the cushing an interview registered nurse (Rare to follow the baths. RN-A further staff and using a loss only indicate yes.)	nily indicated they washed at cushion three times due to g of urine. NA-A documented acility aware of the concerns. on 11/23/21, at 10:18 a.m. R4 k in sentences and he could to to questions. R4 stated no ting regular baths; stated yes pol baths; stated yes, he wants ripool baths per week as was dmission; stated yes, it makes of clean when he does not get amounts of time; and stated ted staff to give him a whirlpool to follow up on his request. on 11/23/21, 10:47 a.m. POA) stated R4 had informed getting his whirlpool baths. The DON on 11/12/21, and DON rected them to immediately on 11/23/21, at 9:35 a.m. NA)-A stated NA's should be to not all NA's are completing fare doing bed baths or hand at. NA-A stated there just isn't be number of NA staff on duty. on 11/23/21, at 12:08 p.m. N)-A stated nursing assistants the schedule and complete stated, the facility is short to fagency staff, that do not tugh with their bathing	F 67	77		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED					
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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ST JAMES		1000	EET ADDRESS, CITY, STATE, ZIP CODE O SOUTH SECOND STREET JAMES, MN 56081	,	0,2021			
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F 677	During an interview DON stated R4's bais disappointed with DON stated after a she went to staff an whirlpool bath immer facility has had staff excuse for not proven During an interview NA-B stated some staff, are not compled documenting that the stated, the facility is NA's. During an interview RN-B stated the lass with having enough stated, there have be considerable tension. The facility Care Pla 9/17/21, directed the provided the necessite is disappeared by the stated of the provided the necessite is disappeared by the stated of the state	on 11/23/21, at 12:16 p.m. aths are not getting done and a staff for not completing them. family meeting on 11/12/21, ad directed to complete R4's ediately. DON stated the fing challenges but that is no iding resident baths. on 11/23/21, at 12:55 p.m. NA staff, especially agency NA eting the baths and/or not ney completed the bath. NA-B is short staffed, but especially on 11/23/21, at 12:59 p.m. at few months have been tough staff on duty. RN-B further been mistakes and	F 6	77						



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 10, 2021

Administrator Good Samaritan Society - St James 1000 South Second Street St James, MN 56081

Re: State Nursing Home Licensing Orders

Event ID: W4D211

Dear Administrator:

The above facility was surveyed on November 22, 2021 through November 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The 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 number and the corresponding text of 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 that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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.

Good Samaritan Society - St James December 10, 2021 Page 2

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response Licensing and Certification Program Health Regulation Division Minnesota Department of Health Midtown Square 3333 Division Street, Suite 212 Saint Cloud, Minnesota 56301-4557 Email: susie.haben@state.mn.us

Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Flig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00697		B. WING		I	C 23/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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2 000	Initial Comments			2 000			
	****ATTEI	NTION*****					
	NH LICENSING	CORRECTION O	RDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected.	ction order has be y. If, upon reinsp iency or deficience ected, a fine for each assessed in actines promulgated artment of Health. The there a violation is several items, the items will be compliant of multipment of a fine every ment of a fine every life, and the items will be compliant to the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of a fine every life, and the items will be compliant of the items will be com	en issued ection, it is ies cited ach violation cordance by rule of has been ll he tag ed below. failure to onsidered act upon art rule will en if the item				
	You may request a that may result from orders provided that the Department with notice of assessme	n non-compliance t a written reques hin 15 days of rec	with these t is made to eipt of a				
Minnesota D	INITIAL COMMENT On 11/22/21 and 11 was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction you and identify the date	/23/21, a complai our facility by a su artment of Health OT in compliance ease indicate in yo ou have reviewed	rveyor from (MDH). Your with the MN our electronic these orders				
	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRES	SENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

Electronically Signed 12/17/21

STATE FORM 6899 If continuation sheet 1 of 8 W4D211

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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GOOD S	AMARITAN SOCIETY	- ST JAMES		ITH SECONE S, MN 56081			
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2 000	Continued From pa	ge 1		2 000			
	The following complaint was found to be SUBSTANTIATED:						
	H5593035C (MN78 issued at S840. H5593033C (MN78 H5593033C (MN78 (MN78694), however due to actions implessurvey. Minnesota Department the State Licensing Federal software. The assigned to Minness Nursing Homes. The appears in the far-letted in the "Summ column and replace the correction order the findings which a statute after the state as evidence by," For are the Suggested.	641 and MN7865 586) and H55930 er, NO deficiencing emented by the farment of Health is of Correction Order ag numbers have to a state statutes are assigned tag number to comply the column entitle tute/rule out of column also are in violation of tement, "This Ruollowing the survey Method of Correction MN7865.	50), 037C es were cited acility prior to documenting rs using e been strules for umber d "ID Prefix ompliance is Deficiencies" /" portion of so includes the state le is not met pyor's findings				
	Time Period for Con You have agreed to receipt of State lice the Minnesota Depa Informational Bullet https://www.health.s n/infobulletins/ib14_	participate in the nsure orders con artment of Health in 14-01, availabl state.mn.us/facili	sistent with e at:				
	The State licensing attached Minnesota being submitted to no plan of correction Statutes/Rules, plea	Department of H you electronically n is necessary fo	Health orders . Although r State				

Minnesota Department of Health

STATE FORM 6899 W4D211 If continuation sheet 2 of 8

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		00697		B. WING		I	23/2021
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PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
2 000	Continued From pa	ge 2		2 000			
	"CORRECTED" in to must then indicate in licensure process, undate, the date your to electronically subsequence between the bottom of the fire please DISREGA FOURTH COLUMN	in the electronic Sta under the heading of orders will be corre- omitting to the Minne lth. The facility is en- e a signature is not est page of state for ARD THE HEADING WHICH STATES,	ate completion cted prior esota nrolled in required at m.				
2 840	"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. 40 MN Rule 4658.0520 Subp. 2 B Adequate and		2 840			12/24/21	
2010	Proper Nursing Car		ite and	2010			12/24/21
	Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:						
	B. Clean skin a odors. A bathing pl resident's plan of ca condition requires the must be given a condition other day and more incontinent resident every two hours, an following each episo	are. A resident who hat the resident rem mplete bath at least often as indicated. It must be checked and must receive per series.	each ose nain in bed t every An at least ineal care				
	[144A.04 Subd. 11 Notwithstanding Mil 4658.0520, an inco- checked according written in the reside attending physician interval longer than	nnesota Rules, part ntinent resident mu to a specific time in ent's care plan. The must authorize in	st be lterval resident's writing any				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00697		B. WING			23/ 2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ST JAMES	1000 SOU	DRESS, CITY, S ITH SECONE S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED I SC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 840	Continued From paid if competent, or a far appointed conserval agent of a resident in writing to waive put determining this into documented in the Clean linens or cloth promptly each time Perineal care include the perineal area. It to keep the bed dry comfort. Special at skin to prevent irritat types of protectors completely covered contact with the resident areas to president areas to pres	amily member or leastor, guardian, or he who is not compet only sician involvements and this wait resident's care planting must be proviethe bed or clothing les the washing and for the residentention must be given and for the residentention. Rubber, plasmust be kept clear, and not come in a dident. Soiled linententententententententententententent	ealth care ent, agrees ent in ver is n.] ded g is soiled. d drying of ust be used nt's ven to the stic, or other n, be direct and	2 840			
	This MN Requirements by: Based on observation reviewed, the facility daily living (ADL), so regular bathing for dependent upon states Findings include:	on, interview and o y failed to provide a pecifically persona 1 of 3 residents (Raff for personal car	document activities of I hygiene of 4) who were es.		Corrected		
	R4's Face Sheet pr was admitted to the R4's primary admitt include cognitive co (difficulty in verbally Gravis (neurologica of limbs and proble	facility on 8/19/21 ing diagnoses date immunication disor communicating), Il disease-causing	ed 8/19/21, rder Myasthenia weakness				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			, DOILDING.			
		00697	B. WING		1	3/2021
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES	TH SECONE 5, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	R4's Care Plan last directed that R4 ha bowel related to im assistance with trar communication pro Gravis and a hearir neurological status evidenced by sever alteration in activity speech evidenced understanding R4's breath related to M decreased energy, impairment; and haperformance deficit and requires limited bathing/showering. R4's Medicare 5-Dadated 8/26/21, door on the brief intervie assessment indicate	nd urinary incontinence. It revision dated 9/28/21, It defrequent incontinence of paired mobility and required insfers and toileting; had a blem related to Myasthenia ing deficit; has an alteration in related to Myasthenia Gravis in the muscle weakness; had involvement related to unclear by staff having difficulty in requests; has shortness of yasthenia Gravis evidenced by fatigue, and musculoskeletal in an ADL self-care in related to Myasthenia Gravis in assist of one staff with	2 840	DE. NOLENO.		
	11/23/21, had R4 s during the Sunday during the day shift	#1 Bath Schedule copied cheduled for a whirlpool bath evening shift and Wednesday . Directions at the bottom of ed, "do not change without manager."				
	October and Nover 11/23/21, documen	entation Survey Report for mber 2021, printed on ted R4 was to receive fifteen ing 10/01/21 - 11/23/21 but				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		DED: I `	1 ` '			(X3) DATE SURVEY COMPLETED	
AND FEMALES HOLD	IDENTIFICATION	Α Α	A. BUILDING: .				
	00697	E	B. WING		11/2	; 3/2021	
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, S	TATE, ZIP CODE			
GOOD SAMARITAN SOCIETY	- ST JAMES	1000 SOUTH ST JAMES,					
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
nursing (DON)) 11/14/21 - no bath 11/21/21 - whirlpool On 10/11/12, nurse documented in the r summary reporting her that R4 smelled the facility was not p Additionally, the fam R4's wheelchair sea the cushion smelling that she made the familiar that she made the familiar that she made the familiar that he was not getted that he liked whirlpool to have the two whire set-up during his addim feel sad and not a bath for extended yes that he has asked bath, but they did not buring an interview.	bath bath (directed by directed by directed by directed by directed by directed by directed bath practitioner (NP)-A medical appointment the family sent a mes of urine and was con	sage to ocerned shed due to mented encerns. a.m. R4 e could ed no ted yes he wants as was t makes in not get distated whirlpool uest.	2 840				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00697		B. WING		I	C 23/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ST JAMES		ITH SECOND S, MN 56081			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 840	Continued From pather that he was not POA reported this to went to staff and distant R4. During an interview nursing assistant (Noting the baths, but them. Instead, staff washing the resider enough time with the During an interview registered nurse (Rare to follow the baths. RN-A further staff and using a lot seem to follow throus assignments. During an interview DON stated R4's batis disappointed with DON stated after a she went to staff and whirlpool bath immediacility has had staff excuse for not provus During an interview NA-B stated some I staff, are not compled ocumenting that the stated, the facility is NA's.	getting his whirlp to DON on 11/12/2 rected them to im on 11/23/21, at 9 NA)-A stated NA's to are doing bed bant. NA-A stated the number of NA stated nursing the schedule and contact the facility of agency staff, to a stated, the facility of agency staff, to a stated, the facility of agency staff, to a staff for not comfamily meeting or a directed to comfamily mee	21, and DON mediately :35 a.m. should be completing ths or hand ere just isn't staff on duty. 2:08 p.m. ng assistants omplete y is short hat do not ning 2:16 p.m. g done and pleting them. n 11/12/21, plete R4's ted the ut that is no hs. 2:55 p.m. ly agency NA nd/or not bath. NA-B	2 840			
	During an interview RN-B stated the las with having enough stated, there have b	t few months hav staff on duty. RN	e been tough -B further				

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		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00007		B. WING			C	
		00697		B. WINO		11/2	23/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
GOOD SAMARITAN SOCIETY - ST JAMES 1000 SOUTH SECOND STREET ST JAMES, MN 56081								
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
2 840	2 840 Continued From page 7			2 840				
	considerable tension between staff.							
	The facility Care Plan, last reviewed/revised 9/17/21, directed that residents will receive and be provided the necessary care that meet emotional and physical professional standards of care. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' care planned needs and request. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently.							
	TIME PERIOD FOF (21) days.	R CORRECTION: Tw	venty-one					

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