Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 29, 2023

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

RE: CCN: 245593
Cycle Start Date: May 11, 2023

Dear Administrator:

On May 24, 2023, we notified you a remedy was imposed. On June 15, 2023 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 May 31, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 8, 2023 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of May 24, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 11, 2023. 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

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
May 24, 2023

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

RE: CCN: 245593
Cycle Start Date: May 11, 2023

Dear Administrator:

On May 11, 2023, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 11, 2023, the situation of immediate jeopardy to potential health and safety cited at F0600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 8, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 8, 2023 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 8, 2023, (42 CFR 488.417 (b)).

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.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - St James is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 11, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

correction (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 "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 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 November 11, 2023 (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 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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) 565-9462

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	C 05/11/2023

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/8/23, 5/9/23, and 5/11/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F600 began on 4/19/23, when facility failed to ensure resident protection when NA-A verbally abused R1 and failed to protect residents when R4 physically assaulted R5. The DON and Administrator-B were notified of the immediate jeopardy at 5:46 p.m. on 5/9/23. The IJ was removed on 5/11/23. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 5/11/23. The following complaints were reviewed. H55932103C (MN00093205); H55931780C (MN00092955); H55931781C (MN00093033) and H55932020C (MN00093159) with a deficiency issued at F600 and F609. 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		

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

Electronically Signed | 05/31/2023

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 SS=J	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- §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 observation, interview, and document review the facility failed to ensure resident protection when NA-A verbally abused 1 of 2 residents (R1) who complained of abuse. Additionally, the facility failed to protect residents when R4 physically assaulted 1 of 1 resident (R5) who expressed ongoing fear of R4. The facility's failure resulted in an immediate jeopardy for (R1 and R5). The IJ began on 4/19/23, when nursing assistant (NA)-A returned to work without training after calling R1 bitch causing R1 to express ongoing fear of verbal abuse. Additionally, on 4/29/23, R4 wandered into R5's room and choked R5. The DON and Administrator-B were notified of the immediate jeopardy at 5:46 p.m. on 5/9/23. The immediate jeopardy was removed on 5/11/23, but noncompliance remained at the lower scope and severity level 2 D - isolated scope and severity	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. RN-A was reeducated per organization's policy but has since resigned. NA-A subsequently resigned.	5/31/23

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F 600	Continued From page 2 level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Employee to Resident Review of the 4/25/23, anonymous Vulnerable Adult Maltreatment Report to the State Agency (SA) indicated an employee (later identified as NA-A) called a resident (later identified as R1) a "bitch" and was told not to report it. R1's quarterly Minimum Data Set (MDS) dated 5/4/23, indicated R1 was cognitively intact. The MDS further indicated R1 required assistance of one staff with eating, toileting, personal hygiene, transfers, and mobility. R1's diagnoses included Parkinson's disease and anxiety disorder. R1's Minnesota Vulnerable Adult Assessment dated 3/30/23, indicated R1 can make her needs and concerns known. During observation and interview on 5/8/23, at 1:45 p.m. R1 was in bed resting. R1 indicated NA-A entered her room one morning and shut her call light off and left the room twice. The third time R1 told NA-A not to shut her call light off again. NA-A responded she was shutting the call light off because they (staff) were getting into trouble for long call light wait times. R1 indicated she told NA-A she needed to use the bathroom, was still continent, and wanted to stay that way. R1 indicated NA-A called her a "bitch" as she left the room. R1 further indicated she was upset and crying, another staff person told her to report it to the administrator. R1 further reported she had	F 600	R4 discharged from the facility on 5/9/23. All staff were re-educated on the Abuse and Neglect Policy and Procedure which includes resident to resident altercations on 5/10/2023. 2. All residents have the potential to be affected by the deficient practice. All residents were interviewed on 5/10/23 by Social Services to ascertain if they have been verbally or physically abused by NA-A or RN-A. Staff were interviewed on 5/10/22 and asked if they had concerns with allegations of abuse regarding any of the staff. A review of all residents was completed to assess if there were appropriate interventions in place for those that showed aggressive behaviors. No further allegations have been reported by residents or staff. 3. The organization’s policy on abuse and neglect has been reviewed and is current. All staff were re-educated on Abuse/Neglect policy and procedure which includes resident to resident altercations on 5/10/23. 4. Abuse/neglect audits will be conducted by the Quality Assurance Coordinator or designee for (R1) and (R5) and (3) other random residents twice weekly x 4, then weekly. Results will be brought to the QAPI committee for input on the need to increase, decrease, or discontinue audits. 5. 5/31/23	

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F 600	Continued From page 3 Parkinson's medications, and it was important to get them on time. Because of Parkinson's she could only take one pill at a time with a sip of water in between. R1 also indicated she was afraid to put her call light on because NA-A might get mad at her, or they might not answer her call light at all. During the interview R1 was crying and visibly shaking. A review of the facility investigative file related to NA-A included a typed statement from R1 dated 3/28/23 that indicated R1 had requested assistance from NA-A and NA-A called her a "bitch". The file also included NA-A's undated hand written statement. NA-A's statement included "I have someone else to tend to, I turned walked in the hall, I thought what a bitch and I whispered it, and well she heard me." The director of nursing's (DON) typed stated dated 3/28/23, indicated there was a discussion with NA-A with the conclusion NA-A would complete additional Vulnerable Adult training prior to returning to the floor and would not work on the same hallway as R1. The file also included a disciplinary action form dated 3/29/23 that included section labeled Summarize issues or reference any policies that have been violated based on concerns with performance documentation. The section included bullets of Abuse and Neglect. Also included, "The above behavior goes against the Code of Conduct. The behavior is not appropriate and will not be tolerated. You will be required to complete Vulnerable adult training as assigned by the DNS prior to returning to work on the floor." NA-A training record between 3/28/23 to 5/8/23, it was evident NA-A had not completed the assigned Vulnerable Adult training prior to	F 600		

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F 600	Continued From page 4 returning to work on the floor as identified in the facility investigation file. NA-A's Time Card Report identified NA-A worked the following days: March 28, 29, 30, 31; April 1, 2, 3, 4, 5, 19, 20, 21, 22, 24, 26, 28, 28, 30; May 1, 3, 4, 8. During an interview on 5/8/23, at 3:45 p.m. NA-A indicated she should have stayed home on 3/28/23, the day of the incident that happened with R1. NA-A had been irritated because of a staff meeting held the day before that related to unacceptable long call light times. NA-A stated she did call R1 a "bitch" and left her room. NA-A further stated the DON and HR-A talked to her, but "didn't suspend or fire me". NA-A stated she had to write a statement of what happened and was supposed to watch some videos but has not had the time to watch them yet. NA-A stated since the incident with R1 she has been providing care to residents. NA-A indicated the DON did not want her working down R1's wing but she received pressure from other staff. NA-A explained she was directed by the charge nurse to work R1's hallway but could not always avoid working with R1 because of staffing. NA-A indicated administrator-A had received further complaints from R1 about her. Administrator-A sent her home for about a week and a half from approximately 4/5/23 to 4/18/23, but then she was able to return to work. NA-A stated she was not aware what happened with her employment during the time she was taken off the schedule and why she was asked to return to work. During an interview on 5/8/23, at 3:00 p.m. the director of nursing (DON) indicated she was	F 600		

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F 600	Continued From page 5 aware of the incident between NA-A and R1 that occurred on 3/28/23. Verified NA-A did call R1 a bitch, she was supposed to suspend her, but NA-A had already left for the day. DON further indicated she talked to human resource representative (HR-A) and decided to have NA-A write a statement of what happened and do some vulnerable adult education. The investigation was completed between NA-A's scheduled shifts. The investigation included talking to the resident and NA-A. The DON indicated she was aware of the incident R1 and NA-A but was out of the facility on vacation so did not do that investigation. During a follow-up interview on 5/9/23, at 12:00 p.m. the DON indicated she was not aware that NA-A had not completed the required education prior to returning to the floor the next day (3/29/23) and stated, "if she (NA-A) knew she was supposed to do the training then it was her responsibility." During a phone interview on 5/9/23, at 12:30 p.m. HR-A indicated "technically" NA-A was only suspended overnight between her two shifts on 3/28/23 and 3/29/23. Administrator-A did the investigation, HR-A talked to NA-A via phone on 3/28/23, about R1's complaint. Further indicated she had not met with NA-A and NA-A had not acknowledged the Disciplinary Action form. NA-A was not supposed to work with R1 but was put back on R1's wing by charge nurse orders. R1 had more complaints on 4/5/23, but was not aware of what those complaints were. NA-A was removed from the schedule at that time and returned to work on 4/19/23. HR-A stated NA-A was not physically presented disciplinary action in person and had not acknowledged it through their online system for the 3/28/23 incident.	F 600		

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	245593	A. BUILDING _____ B. WING _____	C 05/11/2023

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F 600	Continued From page 6 During an interview on 5/9/23 at approximately 12:45 p.m., Administrator-B indicated he had started his duties at the facility on 4/25/23 and was not involved in any of the investigations but would expect the investigation and assigned education to be completed prior NA-A returning to work with the residents. Resident to Resident R4 and R5 Review of the 4/29/23, FRI to the SA identified R4 entered R5's room on 4/29/23, at 2:21 p.m. and choked R5. The five-day investigation summary received on 5/2/23, indicated R4 became agitated after R5 asked him to leave his room and then began hitting and choking R5. R4's admission MDS dated 2/20/23, indicated R2 had impaired cognition. The MDS further indicated R4 was independent with ambulation but required staff assistance with dressing, bed mobility, toileting, and personal hygiene. R4's diagnoses included dementia, anxiety disorder, delusional disorders, diabetes, and cancer. R4's care plan last revised on 5/1/23, indicated R4 had a behaviors of wandering, rummaging behaviors, threatening, hitting, grabbing, or choking. Corresponding interventions indicated staff to intervene as necessary, approach in a calm manner, divert attention, and remove from situation. Additional interventions updated on 5/1/23 was to offer snacks or beverage, provide one to one activity, and monitor every 10-15 minutes. Also identified R4 at risk for elopement and intervention was to monitor R4 every two hours but also included for a nurse to do a visual	F 600		

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F 600	Continued From page 7 check on R4 every 5-10 minutes. Review of Point of Care (POC-NA documentation platform) identified every two hour checks were completed, however April treatment administration record (TAR) identified every 10-15 minute checks were not completed in accordance to the care plan. R4's progress notes were reviewed in conjunction with R4's Behavior Log from 4/9/23 to 5/8/23. The records identified R4 had escalating wandering/physical/verbal behaviors. Further it was not evident behaviors and interventions were assessed or evaluated for effectiveness and not evident the care plan was revised. Additionally, not evident the physician was notified of the increase in abusive behaviors. R4's Progress notes included the following: 4/18/23 at 10:04 p.m. R4 entering resident rooms and upsetting them, yelled at staff, clenched, and unclenched hands at nurse when being redirected. 4/20/23 at 2:06 p.m. R4 rummaging in resident rooms, staff areas, garbage, laundry, kitchen, and dining areas. Does not respond to re-direction. 4/22/23 at 8:56 a.m. R4 requires frequent staff re-direction related to wandering into other resident's rooms and inappropriate areas. 4/22/23 at 7:34 p.m. R4 entered a female resident's room. Female resident yelling at him to get out. R4 then shook his hands in her face. 4/23/23 at 3:40 p.m. R4 wandered into a female resident's bathroom to wash his hands. Female resident yelling for someone to get him out. 4/25/23 at 12:01 p.m. R4 wandering into other resident's rooms. 4/25/23 at 10:08 p.m. R4 exit seeking and going	F 600		

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F 600	Continued From page 8 into other resident's rooms. Resident entered a resident room with nurse attending to resident, R4 grabbed nurse and would not let go, another nurse intervened. 4/27/23 at 10:58 p.m. R4 wandering into other resident's rooms and upsetting them. 4/28/23 at 9:37 a.m. R4 wandered into a female resident's room and told her to "kiss my ass" and then walked out. Female resident visibly upset. 4/29/23 at 2:34 p.m. R4 was brought to the nurse's station for distance. Continues to attempt to wander. R5 in his room calming. Progress notes did not address and/or mention the incident of R4 choking R5 4/29/23 at 3:45 p.m. R4 no injury noted and will be within eyesight of at least one staff through out shift. 5/1/23, at 12:09 a.m. R4 has wondered all shift, redirected numerous times from other resident room in a gentle manner. 5/1/23, at 5:00 a.m. R4 came out and started talking to female resident that when she found her boyfriend she better watch out. He raised a folded magazine in her face. When staff intervened he raised his fists. 5/1/23, at 12:25 p.m. R4 was seen by nurse practitioner who wrote a new order to increase Seroquel (antipsychotic medications) to 50 milligrams at noon. 5/2/23, at 10:47 p.m. R4 was talking nonsense. He reached out and hit her in her left chest. A subsequent note at 10:51 p.m. indicated R4 was verbally abusive toward staff and threatened the nurse he would send her "To the f**** moon". R5's Admission MDS dated 4/26/23, indicates R5 is cognitively intact. R5 requires extensive assist with bed mobility, transferring, walking, mobility, dressing, and toileting. R5's Diagnoses list	F 600		

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F 600	Continued From page 9	F 600		

includes spinal stenosis (narrowing of the spinal cord), cervical disc displacement, cervicalgia (neck pain), and left shoulder pain.

R5's Progress Notes indicate the following:
4/29/23, at 3:18 p.m. R5' upper torso and head were checked for injury with no injuries noted. R5 up and about as usual. R5's record did not identify why R5 was checked for injury.
4/29/23, at 8:57 p.m. one to one conversation with R5 reassured him with monitoring of R4.
5/4/23, at 11:50 a.m. R5 requests staff ensure R4 remains away from him.
5/1/23, at 12:16 p.m. certified nurse practitioner (CNP) visited R5. Reported R5 had a headache right after the event but is resolved now. CNP ordered Tramadol 50 mg one tablet every night and twice a day as needed for breakthrough pain.

During an observation and interview on 5/8/23, at 10 a.m. R5's room door was open with a mesh stop sign wrapped around the handrail next to the door. R5 wheeled himself to his room at the far end of the hallway. R5 indicated about a week prior R4 entered his private room and tried to beat him up. R5 further explained R4 wanders into his room and other resident's rooms frequently. R5 came out of his bathroom to find R4 standing in his room. When he told R4 to leave his room, R4 said it was his room and hit and grabbed at him. R5 put the call light on for staff to come in as staff had instructed him to do but, when he turned his back, R4 started choking him and trying to throw him down on the ground. R4 stated staff were not responding to the call light so he began to scream, and a neighboring resident finally heard him and went to find a staff person for him. Staff then removed R4 from his room. R5 indicated he had a sore neck for a few

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F 600	Continued From page 10 days and didn't sleep that night in fear that R4 would come back to his room and smother or hurt him in his sleep. R5 further indicated staff tried to keep R4 from coming down the hallway that his room is on but also indicated the facility was short on staff and he would feel safer after R4 leaves the facility. During an observation on 5/8/23, at 11:27 a.m. R4 walked into the dining room and attempted to grab utensils sitting on tables. Dietary staff intervened and told R4 to sit down and not to touch anything but his own place setting. During an observation on 5/8/23, at 10:34 a.m., R4 was independently wandering the hallways and entering rooms with no staff observation. During an observation and interview on 5/9/23, at 10:26 a.m. R2 indicated she liked her door shut because there was a man would come into her room and sit in her chair. The man would leave when she told him to. R2 indicated she was not scared of the man. During an interview on 5/9/23, at 10:45 a.m. NA-C indicated R4 was a "handful", he has sworn at and threatened other residents and visitors. Further indicated staff tried to keep an eye on him and keep him from going to R5's hallway. The stop banners across resident doorways did not always work. The female residents feared R4 and the male residents will get "gruff with him". They [residents] have all seen his "feistiness". After the altercation between R4 and R5 staff needed to check on him every hour, but it was hard to do when he moved so fast and there was only one nursing assistant in the facility at times. NA-C indicated weekend staffing was "pretty rough".	F 600		

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F 600	Continued From page 11 During an interview on 5/8/23, at 11:15 a.m. NA-B indicated R4 was in and out of resident rooms "all the time". He would upset residents when he took things from their rooms or off their plates in the dining room. Further indicated the residents yell at him which aggravates R4. R4 would then yell but they were short staffed and could not always get to him in time. The stop signs did not help because R4 would take them down or go under them. NA-B indicated staff instructed the residents not to yell at R4, so he would not get angry. Staff tried to keep a closer eye on R4 but there was not enough staff to do that; sometimes there was only one certified nursing assistant, one medication aid, and one nurse for 31 people. NA-B was unaware of any further direction or interventions made after the incident between R4 and R5. During an interview on 5/8/23, at 2:30 p.m. LPN-A indicated R4 had been more aggressive, wandered into other resident's rooms and took their things. Residents would yell at which further aggravated him. LPN-A was aware of the incident between R4 and R5. The intervention was to try and monitor him 24/7 and redirect him if he went into resident's room. LPN-A indicated there was not enough staff in the building to monitor him as closely as they should. Some of the residents have boxed up their stuff until R4 moved out. During an interview on 5/8/23, at 3:00 p.m., DON indicated R4 and R5 saw their doctors'. Interventions were put in place like one to one supervision, snack, 15 minute checks, TV, R4's antipsychotic medication was increased, and worked on finding other placement for R4.	F 600		

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F 600	Continued From page 12 During an interview on 5/8/23 at 3:45 p.m. NA-A indicated an awareness of R4's abusive behaviors. NA-A was unaware of any changes or protections put into place after the altercation between R4 and R5. NA-A explained staff used the portable radios to ask if anyone has seen him but staff could not drop what they are doing to go look for him. Many residents had complained to her about R4 and wanted him to leave because he took their personal possessions such as hearing aides and eyeglasses. During an interview on 5/9/23, at 11:00 a.m., RN-A indicated she was aware of the altercation between R4 and R5 and they try to keep R4 from going down R5's hallway. R4 wandered into other resident's rooms and would take their stuff. When someone yelled at him to get out of their room, he would swear at them and sometimes throw things before he left the room. R5 did tell her that he feared R4 and did not want him anywhere near him. After the altercation between R4 and R5, 15-minute checks were implemented however, there were times when there had been only one nurse and one aide to care for 33-34 residents which made the every 15-minute checks difficult. The facility policy Abuse and Neglect dated 10/13/22, directed a resident has a right to be free of abuse. The location will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. The immediate jeopardy that began on 4/19/23, was removed on 5/11/23, when the facility took the following actions: Completed thorough investigations of the abuse	F 600		

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F 600	Continued From page 13 allegations which included interviewing other residents and staff to identify if other residents had been affected by abuse or have been abused by anyone. NA-A were suspended pending corrective action, investigation, and training. R4 was discharged from the facility on 5/10/23 All staff were educated on the facility's abuse policy, including how to recognize alleged abuse, resident protection, and when to report abuse.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		5/31/23

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F 609	Continued From page 14 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report allegations of abuse timely to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse. Findings include An anonymous Vulnerable Adult Maltreatment report submitted to the State Agency on 4/25/23, at 1:02 p.m., alleged caregiver abuse when nursing assistant (NA)-A called R1 a "bitch". R1's quarterly Minimum Data Set (MDS) dated 5/4/23, indicated R1 was cognitively intact. The MDS further indicated R1 required assistance of one staff with eating, toileting, personal hygiene, transfers, and mobility. R1's diagnoses included Parkinson's disease and anxiety disorder. During an interview on 5/8/23, at 1:45 p.m. R1 indicated NA-A entered her room one morning and shut her call light off twice and left the room. The third time R1 told NA-A not to shut her call light off again. NA-A responded she was shutting the call light off because they (staff) were getting into trouble for long call light wait times. R1 stated she needed to use the bathroom, was still continent, and wanted to stay that way. R1 indicated NA-A called her a "bitch" as she left the room. R1 further indicated she was upset and crying, and another staff person told her to report it to the administrator. R1 was crying and visibly shaking during the interview.	F 609	1. Immediate re-education was given to the staff who are mandated reporters including the IDNS, lead social worker, and interim administrator on reporting of abuse and neglect timely per regulations. 2. All residents have the potential to be affected by the deficient practice. All staff were re-educated on timely reporting of abuse and neglect incidents on 5/10/23. 3. The organizations policy on abuse and neglect has been reviewed and is current. All staff were re-educated on Abuse/Neglect policy and procedure on 5/10/23. All alleged violations involving abuse will be reported immediately, but not later than 2 hours after the allegation is made. All alleged violations involving neglect will be reported immediately, but not later than 24 hours after the allegation is made. All alleged violations involving abuse and neglect will be thoroughly investigated and documented. 4. Abuse/neglect audits will be conducted by the Quality Assurance Coordinator or designee for (R1) and (4) other random residents twice weekly x 4, then weekly. Results will be brought to the QAPI committee for input on the need to increase, decrease, or discontinue audits. 5. 5/31/23	

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F 609	Continued From page 15 During an interview on 5/8/23, at 3:45 p.m. NA-A stated she did call R1 a "bitch" as she was leaving the room. NA-A indicated the DON and human resource representative (HR)-A talked with her, but she was not suspended or fired. Further indicated she was given some education to do but had not had time to do it yet. A Facility Reported Incident was not located in the SA system and the facility was unable to provide evidence of submission to the state agency. An anonymous Vulnerable Adult Maltreatment report submitted to the State Agency on 5/2/23, at 8:34 a.m. alleged caregiver abuse when registered nurse (RN)-A shoved a straw so hard into R1's mouth, multiple times that R1's mouth was bleeding and had sores in it following the incident. During an interview on 5/8/23, at 1:45 p.m. R1 indicated RN-A was having a bad day and shoved a straw to the back of her throat multiple times. Further indicated, "it was horrible", the straw was so far back she could suck on the straw to take her pills. During an interview on 5/8/23, at 3:01 p.m. the director of nursing (DON) indicated she was aware of the incident but unaware if a report was filed with the SA. Follow up interview on 5/11/23, at 11:50 a.m. the DON indicated R2 also had an abuse complaint that same day that was reported to the SA and thought R1's allegation were included but that Administrator-A must have omitted it. A review of the facility investigation related to R1 and RN-A indicated on 4/21/23, at 9:42 a.m.	F 609		

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F 609	Continued From page 16 Administrator-A emailed HR-A and the DON. The email indicated staff members reported RN-A was mean and degrading to both residents and staff because she was mandated to stay. Further indicated a resident reported while passing pills, RN-A pushed the straw so forcefully in the resident mouth it caused her to bleed. Administrator-A was going to investigate and report to OHFC (Office of Health Facility Complaints) based on findings. A Facility Reported Incident was not located in the SA system and the facility was unable to provide evidence of submission to the state agency. The Abuse and Neglect Policy last reviewed on 10/13/22, indicated if there is an allegation of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made.	F 609		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 24, 2023

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

Re: Event ID: A51711

Dear Administrator:

The above facility survey was completed on May 11, 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
	00697	A. BUILDING: _____ B. WING _____	05/11/2023

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/8/23, 5/9/23, and 5/11/23 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 H55932103C (MN00093205); H55931780C (MN00092955); H55931781C (MN00093033) and H55932020C (MN00093159). 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		