

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 27, 2022

Administrator Good Samaritan Society - Westbrook 149 First Street, Box 218 Westbrook, MN 56183

RE: CCN: 245595 Cycle Start Date: January 13, 2022

Dear Administrator:

On January 13, 2022, 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.

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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:

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504 Email: nicole.osterloh@state.mn.us Office: 507-476-4230 Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

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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 April 13, 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).

In addition, if substantial compliance with the regulations is not verified by July 13, 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates

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Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

	-	AND HUMAN SERVICES			FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	TE SURVEY
		245595	B. WING_			C / 13/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218		
		- WEOTBROOK		WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0(00		
F 600	abbreviated survey Your facility was fou with the requirement Requirements for L The following comp SUBSTANTIATED: deficiencies cited a The following comp UNSUBSTANTIATED: H5595024C (MN75 (MN74818). The facility's plan of as your allegation of Departments accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat	acceptable electronic POC, an r facility may be conducted to intial compliance with the en attained.	F 6(00		2/25/22
SS=D	CFR(s): 483.12(a)(1)				2123122
	Exploitation The resident has th neglect, misapprop and exploitation as includes but is not I corporal punishmer	rom Abuse, Neglect, and e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and				
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					02/03/2022

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.

		AND HUMAN SERVICES				FORM	02/10/2022 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	Сом	E SURVEY PLETED
		245595	B. WING	;			_ 13/2022
NAME OF	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218 WESTBROOK, MN 56183			
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F 600	Continued From pa	ige 1	F	600			
		mical restraint not required to medical symptoms.					
	§483.12(a) The fac	ility 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 interview facility failed to ensi abuse for 1 of 1 res	ed on interview and document review, the y failed to ensure residents were free from e for 1 of 1 resident (R6), who was willfully < on the back of the head by R1.			Administrator and interdisciplinary will review policy and procedures regarding resident abuse and negle the 2/24/2022 QAPI meeting.		
	Findings include:				R6⊡s care plan updated on 1/20/20 DNS and Social Services Coordina		
	State Agency (SA) resident-to-resident at 5:20 p.m R6 wa dining room and pa purposefully wheele struck him on the b	22 at 3:58 p.m., report to the identified an allegation of t abuse occurred on 12/19/21 as reported to be leaving the assed by R1, who turned and ed herself behind R6 and ack of the head with her open ned and separated R6 and R1.			ensure free from abuse by R1. All other residents care plans were reviewed and updated on 2/4/2022 DNS and Social Services to ensure are free from abuse, neglect, misappropriation of resident proper exploitation.	by they	
	identified R1 had se required limited ass locomotion and exte for all other activities wheelchair for mob independently as sl facility. R1's diagno anxiety and depress documented during period.	erly Minimum Data Set (MDS) evere cognitive impairment, sistance of one staff for ensive assistance of one staff es of daily living. R1 used a ility and was able to move he wandered throughout the bases included dementia, sion. There were no behaviors the assessment reference ed care plan identified R1 had			All staff will be re-educated by 2/25 regarding abuse and neglect. Social Services Coordinator or des will conduct audits weekly for one r and monthly for two more months t ensure residents are free from abu neglect and exploitation. Social Services Coordinator or des or designee will present findings of at monthly QAPI meetings for revie recommendations.	ignee nonth o se, ignee audits	

Facility ID: 00082

		AND HUMAN SERVICES				FORM	: 02/10/202 APPROVE . 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	COM	e survey Ipleted
		245595	B. WING				C 13/2022
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK			49 FIRST STREET, BOX 218 VESTBROOK, MN 56183		
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F 600	Continued From pa	age 2	F6	600			
	 Continued From page 2 a mood disorder related to a diagnosis of dementia. R1 would refuse cares, showed physical aggression, and was short tempered. Staff were to monitor for mood patterns. When R1 was physically aggressive, staff were to provide 1:1 monitoring and attempt to distract with providing a snack and ask R1 to help with duties. There was no mention of any added interventions specific to preventing further abuse by R1 to R6 or other residents who may be at risk. R6's 11/4/21, quarterly MDS assessment identified moderate cognitive impairment, limited assistance of one staff with activities of daily living (ADL)s, and supervision was needed with locomotion on/off the unit. R6's diagnosis included disorientation and anxiety, but there was no behavior identified during the assessment reference period. 				Administrator will monitor complian this correction.	ice on	
	anxiety. R6 had a s enjoyed/initiated so There was no men further abuse by R needed to prevent Observations on 1/ p.m. identified R1 v quickly throughout be interviewed whe Observation on 1/1	212/22 from 10:00 a.m. to 2:00 was able to wheel herself very the facility. R1 was unable to en interview was attempted. 2/22, from 10:00 a.m. to 2:00					
	wheelchair, and inc from his room to th hall. R6 was observ	was observed in his dependently wheeled himself e commons area and in the ved speaking with residents noted to ask repeated					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUPW COMPLETED AND PLAN OF CORRECTION AND PLAN OF CORRECTION STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183 OMB NO. 0938 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O/(PAP) Interview on 1/12/22 at 1:26 p.m. with licensed practical nurse (LPN)-B identified R1 had a history of "incidents" with different residents and staff attempted to redirect and keep those residents separated. R1 was frequently at the nursing station where staff were able to monitor and intervene if necessary. R1 tended to "sundown" (a state of confusion occurring in the late afternoon and extending into the night), with outbursts of anger, and rapid mood changes from ID PROVIDERS ID PROVIDERS				E SURVEY			
		245595					
NAME OF F	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	• • •	
		WESTBROOK		14	19 FIRST STREET, BOX 218		
GOOD S	AMARITAN SUCIETY	- WESTBROOK		W	ESTBROOK, MN 56183		
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							COMPLETION DATE
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245595 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - WESTBROOK STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - WESTBROOK STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 WESTBROOK INPOVIDER OR SUPPLIER ID PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Continued From page 3 F 600 Continued From page 3 F 600 Interview on 1/12/22 at 1:26 p.m. with licensed practical nurse (LPN)-B identified R1 had a history of "incidents" with different residents and staff attempted to redirect and keep those residents separated. R1 wandreed through out the facility and there were residents who did not							
F 600		ge 3	F 60	00			
	questions.	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 ontinued From page 3 Juestions. F 600 F 600 terview on 1/12/22 at 1:26 p.m. with licensed ractical nurse (LPN)-B identified R1 had a story of "incidents" with different residents and aff attempted to redirect and keep those esidents separated. R1 wandered through out the facility and there were residents who did not tervene if necessary. R1 tended to "sundown" a state of confusion occurring in the late fernoon and extending into the night), with JUBURST St anger, and rapid mood changes from easant to angry and aggressive. Staff were ware and attempted to monitor and to keep her ID PREFIX TAG					
Interview on 1/12/22 at 1:26 p.m. with licensed practical nurse (LPN)-B identified R1 had a history of "incidents" with different residents and staff attempted to redirect and keep those residents separated. R1 wandered through out the facility and there were residents who did not like R1 and staff attempted to keep them separated. R1 was frequently at the nursing station where staff were able to monitor and intervene if necessary. R1 tended to "sundown" (a state of confusion occurring in the late		2 at 1.26 p m, with licensed					
	(a state of confusion occurring in the late afternoon and extending into the night), with						
		her residents from R1's					
	priysical benaviors.						
		2 at 1:26 p.m. with nursing					
		garding R1 and R6 identified				BE COMPLÉTION	
		gs and without warning would					
		nched her fists, and would or "go after" other residents.					
		rial" and did not want other					
		lose to the nurse's station.					
		her residents and tell them to					
		belong there". R6 was d to transport himself back					
		oom to the common area. R6					
	enjoyed visiting with	n staff and other residents and					
		n sat with R1 at times, but did				SHOULD BE COMPLETION	
	have some cognitiv repeatedly ask the	e issues and was known to					
	Topeateury ask the						

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
		245595	B. WING		01	C / 13/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10/2022
GOOD S	AMARITAN SOCIETY	- WESTBROOK				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 600	Interview on 1/12/2 medication aide (TI usually seated by the staff monitoring, as residents who appr Staff would immedia situation at the nurse prevent escalation. behaviors occurred wandered through other resident space altercations with oth occurred in the ever "sundowning". TM aware of any change following the incide closer to the desk to monitoring. R6 was with staff and other and forth from his r himself. Interview on 1/13/2 director of nursing designee (SSD) ide incidences of beha with anxiety at the to family did not want discussion with fam R1 had been a hea and it was thought her behavior. The I stimulation of being activities was a trig not like other reside station and would y mood changed rap	2 at 2:37 p.m., with trained MA)-A identified R1 was he nursing station to allow for a she would yell at other oached her to "get away!". iately separate R1 from a ses station to attempt to TMA-A identified R1's to na daily basis. She also but the facility including into ces. R1 had a history of her residents, which usually ening after supper due to A-A identified she was not ges in R1's plan of care ints. R1 was moved to a room to allow for better staff a pleasant and enjoyed visiting residents and would go back froom to the common area by 2 at 9:56 a.m., with the (DON) and social services entified R1 had increased vior. R1 had some behavior time of admission, but the her on medication. Following nily members it was discovered and social environmental g in the dining room or even in ger for her behaviors. R1 did ents to come to the nursing rell and tell them to leave. R1's idly and without warning, and ne attempt at medication	F 60	0		

Facility ID: 00082

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI T	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:	l` í	NG	· · ·	MPLETED		
		245595	B. WING			С		
	PROVIDER OR SUPPLIER	243333	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	•	/13/2022		
	AMARITAN SOCIETY	- WESTBROOK	149 FIRST STREET, BOX 218 WESTBROOK, MN 56183					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 600	during supper. R1 with her open hand himself, but did have to wander and ask DON confirmed the to the SA due as it had "mental anguis was not aware if th wanted to contact I time of the incident Additional interview the DON identified revealed she beliew went past and inter his head. LPN-A h purpose as she was interviewing LPN-A intentionally followe the back of the hea should have report abuse within the 2- reported the incide Interview on 1/13/2 identified the incide took place in the di 5:20 p.m. on 12/19 agitated prior to the stimulation that have R6 was going back common area. R1 earlier. He continue questions to the nu become upset and making physical ar	n incident with R6 on 12/19/21 hit R6 on the back of the head l. R6 was alert and oriented to ve cognitive issues and tended repetitive questions. The e facility had not filed a report was decided neither R1 nor R6 sh" or was injured. Initially, she ere had been intent, but _PN-A, who was working at the v on 1/13/22 at 2:50 p.m., with she had contacted LPN-A who ved R1 had followed R6 as he ntionally hit him on the back of ad stated, "she did it on s pretty over stimulated". After at the DON determined R1 had ed after R6 and struck him on ad. The DON agreed the facility ed the incident to the SA as hour time period. She had now						

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI	-E CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED
		245505	B. WING			С
		245595				/13/2022
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WESTBROOK	1	BTREET ADDRESS, CITY, STATE, ZIP CO 149 FIRST STREET, BOX 218 NESTBROOK, MN 56183	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 600	seen in his wheelch R1 was seated in h LPN-A observed R wheelchair and roll passing by and strift the back of his hea separated R1 and I and yelling at R6. F identified notified th the MD, and family LPN-A identified sh but had not reporte that to be the response staff if that was need had received educate reporting and what neglect earlier in th she thought about th was agitated and h should have been r and tendency to reate manner toward and go to the dining root had her eat in an attend Review of the 12/20 Neglect-Rehab/Ski identified residents abuse, neglect, mis property and exploit subjected to abuse residents. Alleged of abuse were to be read abuse of resident, for	hair leaving the dining room. her wheelchair at her table. 1 purposefully turn her up behind R6 who was ke him with an open hand to d. LPN-A immediately R6 at that time. R1 was upset R6 stated "Oww!" LPN-A he administrator, DON, SSD, members for both R1 and R6. he had made the notifications, d to the SA as she understood onsibility of the administrative cessary. LPN-A identified she ation on Abuse, VA and constituted abuse and/or e month. LPN-A stated when the incident and knowing R1 ad the tendency to act out, she more aware of R1's agitation act in a physically aggressive other resident and not had her om for the supper meal, but rea away from other residents.	F 600			

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TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT CON	<u>. 0938-039</u> E SURVEY IPLETED C
		245595	B. WING _			/13/2022
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
	residents were to be both ensured a safe determine if a room made. Designated a accordance with sta Agency if there was immediately but not allegation was mad physician and famil situation and inform in progress. The fac was assigned to co the care plan updat put into place. The include interviewing other witnesses to t will be documented designated employe investigations to the within five working of Reporting of Alleger CFR(s): 483.12(c)(1) §483.12(c) In respon neglect, exploitation must: §483.12(c)(1) Ensu involving abuse, ne mistreatment, inclus source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that caus abuse and do not re	e separated immediately and e environment. Staff were to a change was needed to be agencies were to be notified in ate law, including the State an allegation of abuse, t later than two hours after the e. Staff were to notify the y regarding the facts of the them that an investigation is cility would ensure someone mplete the investigation and ed with any new interventions investigation was to include g employees, residents or the incident. The investigation . The social worker or ee will report the results of all e SA and and other officials days of the incident. d Violations	F 60			2/25/22

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1			0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION	CON	E SURVEY IPLETED	
		245595	B. WING _			C 13/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 •		
GOOD S	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218 WESTBROOK, MN 56183			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 609	adult protective ser for jurisdiction in lor accordance with Sta procedures. §483.12(c)(4) Repo- investigations to the designated represe accordance with Sta Survey Agency, with incident, and if the a appropriate correction This REQUIREMENT by: Based on interview facility failed to repo- resident abuse to the timely manner for 2 Findings include: Review of the 1/13/ identified an allegate abuse occurred on was leaving the din who turned and pu- behind R6 and strue head with her open	o the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established	F 60		glect at 2022 by nator to ocial will to ained. re 2 by		
	the facility notified the SA of the abuse of R1 to R6. Interview on 1/13/22 at 9:56 a.m., with both the director of nursing (DON), and social services designee (SSD), identified R1 had rapid mood changes that occurred without warning. The mood changes resulted in anger and aggression directed toward staff and/or other residents that			 ensure they are free from abuse, misappropriation of resident prop exploitation. All staff will be re-educated by 2/2 regarding abuse and neglect. A RCA will be performed by the C Committee by 2/25/2022. 	erty and 25/2022		

		AND HUMAN SERVICES				FORM	02/10/2022 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (COM	E SURVEY PLETED
		245595	B. WING				C 13/2022
NAME OF	PROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK			49 FIRST STREET, BOX 218 VESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	happened to be clo occurred sporadica by environmental si included being in the and/or activities. R day sitting near the would became ang approached the dee with other residents additional incidents residents the DON incident dated 12/1 supper. R1 had str head as he was lea DON and SSD com provided to the adm members and the p been notified as ma been no "mental ar R6. Additional interview the DON identified practical nurse (LPI 12/19/21, who with and R6. LPN-A beli because, "she was DON identified she agreement that R1 wheelchair, moved the back of the head demonstrated internite been reported to the required 2-hour tim 1/13/22 at 4:00 p.m identified following administration, fam	se to her . R1's behavior Illy and seemed to be triggered timulation which at times had be dining room for meals 1 also spent a large part of her nursing station with staff, and ry if other residents sk or if staff were interacting s. When asked about any involving R1 and other and SSD identified the 9/21, which occurred during ruck R6 on the back of his aving the dining room. The firmed notification was ninistrator, DON, SSD, family provider, but the SA had not anagement believed there had aguish or harm", to either R1 or on 1/13/22 at 2:50 p.m., with she contacted licensed N)-A who was working on essed the incident between R1 eved R1 intentionally hit R6 pretty over stimulated". The and the SSD were now in had intentionally turned in her behind R6, and struck him on d. The DON stated R1 had it and the incident should have e SA as abuse within the	F	609	Social Services Coordinator or design will conduct audits weekly for one m and monthly for two more months to ensure residents are free from abus neglect and exploitation. Social Services Coordinator or design or designee will present findings of a at monthly QAPI meetings for review recommendations. Administrator will monitor compliance this correction.	onth be, gnee audits v and	

If continuation sheet Page 10 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/10/2022 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245595	B. WING _				C 13/2022
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	• •	
	AMARITAN SOCIETY	WESTBROOK		14	9 FIRST STREET, BOX 218		
0000 3/	AMARITAN SOCIETT	- WESTBROOK		W	ESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609 F 610 SS=D	SA. Review of the 12/28 Neglect-Rehab/Skil identified residents abuse, neglect, mis property and exploit subjected to abuse residents. Alleged of abuse were to be re administrator. Desig notified in accordant the SA if there was immediately but not allegation was mad The social worker of report the results of and and other officia the incident. Investigate/Prevent. CFR(s): 483.12(c)(2) §483.12(c) In respon neglect, exploitation must: §483.12(c)(2) Have violations are thoroot §483.12(c)(4) Repon investigations to the designated represe	A complete reporting to the A/21, Abuse And led, Therapy & Rehab policy have the right to be free from appropriation of resident tation. Residents must not be by anyone, including, other or suspected violations of eported immediately to the gnated agencies were to be ce with state law, including an allegation of abuse, later than two hours after the e and begin an investigation. or designated employee was to all investigations to the SA als within five working days of //Correct Alleged Violation 2)-(4) mse to allegations of abuse, n, or mistreatment, the facility evidence that all alleged ughly investigated. ent further potential abuse, n, or mistreatment while the rogress.	F 6				2/25/22
	investigations to the designated represe	e administrator or his or her ntative and to other officials in					

If continuation sheet Page 11 of 17

		& MEDICAID SERVICES	0.00			0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	CON	E SURVEY IPLETED		
		245595	B. WING			C 13/2022		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GOOD S	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218 WESTBROOK, MN 56183				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
F 610	Continued From pa	ge 11	F 61	0				
	incident, and if the a appropriate correct This REQUIREMEN by:	hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced						
	Based on interview, and document review, the facility failed to appropriately investigate and identify new interventions following an allegation of physical abuse for 1 of 1 resident (R1). Findings include:		Administrator and interdisciplin will review policy and procedure regarding investigation, prevent correcting allegations of resider neglect, exploitation, or mistrea	ing and it abuse,				
R1's 11/4/21, q identified R1 ha required limited locomotion and for all other act wheelchair for independently facility. R1's dia anxiety and de documented do period. R1's current, u a mood disorde	R1's 11/4/21, quarte identified R1 had se required limited ass	erly Minimum Data Set (MDS) evere cognitive impairment, sistance of one staff for ensive assistance of one staff		the 2/24/2022 QAPI meeting. R1□s allegation of abuse was investigated and new intervention identified on 1/13/2022.	ons were			
	for all other activitie wheelchair for mob independently as sh facility. R1's diagno anxiety and depress	ility and was able to move ne wandered throughout the ses included dementia, sion. There were no behaviors the assessment reference		All other residents were reviewe ensure if allegation of abuse, ne exploitation or mistreatment ap investigation and new interventi identified.	eglect, propriate			
	period. R1's current, undate a mood disorder re	ed care plan identified R1 had lated to a diagnosis of d refuse cares, showed		All staff will be re-educated by 2 regarding investigation, prevent correcting allegations of resider neglect, exploitation or mistreat	ing, and it abuse,			
	physical aggression Staff were to monite R1 was physically a provide 1:1 monitor with providing a sna	n, and was short tempered. or for mood patterns. When aggressive, staff were to ring and attempt to distract ack and ask R1 to help with		Social Services Coordinator or will conduct audits weekly for or and monthly for two more mont ensure allegations of resident a neglect, exploitation or mistreat	ne month hs to buse, ment are			
	interventions specif	no mention of any added fic to preventing further abuse er residents who may be at		investigated, prevented and cor Social Services Coordinator or will continue to monitor that alle abuse, neglect, exploitation or mistreatment are investigated, p and corrected.	designee gations of			

Facility ID: 00082

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	OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MI II TIF	PLE CONSTRUCTION		. 0938-039 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				IPLETED
						С
		245595	B. WING		•	/13/2022
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
GOOD S	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 610	Continued From pa	age 12	F 610	0		
	(ADL)s, and superv locomotion on/off th included disorientation	staff with activities of daily living vision was needed with ne unit. R6's diagnosis tion and anxiety, but there was ed during the assessment		Administrator will monitor co this correction.	mpliance on	
	anxiety. R6 had a s enjoyed/initiated so There was no men	plan identified a diagnosis of social personality and ocial conversations with others. tion of R6 being at high risk for 1 or what interventions were further abuse.				
	p.m. identified R1 v quickly throughout	12/22 from 10:00 a.m. to 2:00 was able to wheel herself very the facility. R1 was unable to en interview was attempted.				
	p.m. identified R6 w wheelchair, and inc from his room to th hall. R6 was observ	2/22, from 10:00 a.m. to 2:00 was observed in his dependently wheeled himself e commons area and in the ved speaking with residents noted to ask repeated				
	practical nurse (LP history of "incidents staff attempted to r residents separated the facility and ther like R1 and staff at separated. R1 was station where staff intervene if necess	2 at 1:26 p.m. with licensed N)-B identified R1 had a s" with different residents and edirect and keep those d. R1 wandered through out e were residents who did not tempted to keep them s frequently at the nursing were able to monitor and ary. R1 tended to "sundown" on occurring in the late				

Facility ID: 00082

If continuation sheet Page 13 of 17

		& MEDICAID SERVICES				0.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			TE SURVEY MPLETED
			A. BUILDIN	G		С
		245595	B. WING		01	/13/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	10/2022
				149 FIRST STREET, BOX 218		
GOOD S	AMARITAN SOCIETY	- WESTBROOK		WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 610	Continued From pa	ae 13	F 61	0		
	• · · · · · · · · · · · · · · · · · · ·	and rapid mood changes from	1 01			
	pleasant to angry and aggressive. Staff were aware and attempted to monitor and to keep her					
		ionitor her. No other				
		noted. LPN-B was unaware if ntion was identified to				
		her residents from R1's				
	physical behaviors.					
	Interview on 1/12/2	2 at 1:26 p.m. with nursing				
		garding R1 and R6 identified				
		gs and without warning would				
		nched her fists, and would				
		or "go after" other residents. rial" and did not want other				
		close to the nurse's station.				
		ther residents and tell them to				
		belong there". R6 was				
		d to transport himself back				
		oom to the common area. R6 n staff and other residents and				
		en sat with R1 at times, but did				
		e issues and was known to				
	repeatedly ask the	same questions.				
	Interview on 1/12/2	2 at 2:37 p.m., with trained				
		MA)-A identified R1 was				
	usually seated by th	ne nursing station to allow for				
		she would yell at other				
		oached her to "get away!". ately separate R1 from a				
		ses station to attempt to				
		TMA-A identified R1's				
	behaviors occurred	on a daily basis. She also				
		out the facility including into				
		es. R1 had a history of				
		ner residents, which usually ning after supper due to				
		A-A identified she was not				

Facility ID: 00082

If continuation sheet Page 14 of 17

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - WESTBROOK 149 FIRST STREET, BOX 218 (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) F 610 Continued From page 14 aware of any changes in R1's plan of care following the incidents. R1 was moved to a room closer to the desk to allow for better staff monitoring. R6 was pleasant and enjoyed visiting with staff and other residents and would go back and forth from his room to the common area by himself. F 610 Interview on 1/13/22 at 9:56 a.m., with the director of nursing (DON) and social services designee (SSD) identified R1 had increased incidences of behavior. R1 had some behavior Interview on 1/13/22 at 9:56 a.m., with the	LETED
245595 B. WING 01/13 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 149 FIRST STREET, BOX 218 GOOD SAMARITAN SOCIETY - WESTBROOK 149 FIRST STREET, BOX 218 WESTBROOK, MN 56183 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 F 610 Continued From page 14 aware of any changes in R1's plan of care following the incidents. R1 was moved to a room closer to the desk to allow for better staff monitoring. R6 was pleasant and enjoyed visiting with staff and other residents and would go back and forth from his room to the common area by himself. F 610 Interview on 1/13/22 at 9:56 a.m., with the director of nursing (DON) and social services designee (SSD) identified R1 had increased incidences of behavior. R1 had some behavior Interview on SCON AND SOCIAL SERVICES	
149 FIRST STREET, BOX 218 WESTBROOK, MN 56183 (X4) JD 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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OP CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OP CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OP CROSS-RE	3/2022
GOOD SAMARITAN SOCIETY - WESTBROOK WESTBROOK, MN 56183 (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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O F 610 Continued From page 14 aware of any changes in R1's plan of care following the incidents. R1 was moved to a room closer to the desk to allow for better staff monitoring. R6 was pleasant and enjoyed visiting with staff and other residents and would go back and forth from his room to the common area by himself. F 610 Interview on 1/13/22 at 9:56 a.m., with the director of nursing (DON) and social services designee (SSD) identified R1 had increased incidences of behavior. R1 had some behavior Westbroad	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 610 Continued From page 14 aware of any changes in R1's plan of care following the incidents. R1 was moved to a room closer to the desk to allow for better staff monitoring. R6 was pleasant and enjoyed visiting with staff and other residents and would go back and forth from his room to the common area by himself. F 610 Interview on 1/13/22 at 9:56 a.m., with the director of nursing (DON) and social services designee (SSD) identified R1 had increased incidences of behavior. R1 had some behavior F 610	
 aware of any changes in R1's plan of care following the incidents. R1 was moved to a room closer to the desk to allow for better staff monitoring. R6 was pleasant and enjoyed visiting with staff and other residents and would go back and forth from his room to the common area by himself. Interview on 1/13/22 at 9:56 a.m., with the director of nursing (DON) and social services designee (SSD) identified R1 had increased incidences of behavior. R1 had some behavior 	(X5) COMPLETIO DATE
with anxiety at the time of admission, but the family did not want her on medication. Following discussion with family members it was discovered R1 had been a heavy smoker, prior to admission and it was thought this could have contributed to her behavior. The DON identified environmental stimulation of being in the dining room or even in activities was a trigger for her behaviors. R1 did not like other residents to come to the nursing station and would yell and tell them to leave. R1's mood changed rapidly and without warning, and there had been some attempt at medication changes due to her change in status. The SSD identified R1 had an incident with R6 on 12/19/21 during supper. R1 hit R6 on the back of the head with her open hand. R6 was alert and oriented to himself, but did have cognitive issues and tended to wander and ask repetitive questions. The DON confirmed the facility had not filed a report to the SA due as it was decided neither R1 nor R6 had "mental anguish" or was injured. Initially, she was not aware if there had been intent, but wanted to contact LPN-A, who was working at the time of the incident .	

Facility ID: 00082

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (CONSTRUCTION	OMB NC	TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	l` í			· · ·	MPLETED
							С
		245595	B. WING				/13/2022
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S/	AMARITAN SOCIETY	- WESTBROOK			FIRST STREET, BOX 218 STBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 610	Continued From pa	age 15	F 6	10			
		ved R1 had followed R6 as he					
	went past and inter	ntionally hit him on the back of					
		ad stated, "she did it on					
		s pretty over stimulated". After , the DON determined R1 had					
		ed after R6 and struck him on					
		d. The DON agreed the facility					
		ed the incident to the SA as					
		hour time period. She had now					
	reported the incide	nt to the SA.					
		2 at 4:00 p.m., with LPN-A					
		ent between R1 and R6 that					
		ning room at approximately /21. LPN-A observed R1 was					
		e supper meal due to					
		d started in the common area.					
		and forth from his room to the					
		had attempted to talk with R1					
		ed to return and ask random rses and to R1. R1 had					
		expressed frustration by					
		id verbal expressions. R1 and					
	R6 had been separ	ated and redirected to the					
		oper. At 5:20 p.m., R6 was					
		nair leaving the dining room. her wheelchair at her table.					
		1 purposefully turn her					
		up behind R6 who was					
	passing by and stri	ke him with an open hand to					
		d. LPN-A immediately					
		R6 at that time. R1 was upset					
		R6 stated "Oww!" LPN-A ne administrator, DON, SSD,					
		members for both R1 and R6.					
	LPN-A identified sh	e had made the notifications,					
		d to the SA as she understood					
	that to be the response staff if that was need	onsibility of the administrative					

Facility ID: 00082

If continuation sheet Page 16 of 17

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245595	B. WING	<u> </u>		С
NAME OF	PROVIDER OR SUPPLIER	240000		STREET ADDRESS, CITY, STATE, ZIP CODE	01	/13/2022
	AMARITAN SOCIETY	- WESTBROOK		149 FIRST STREET, BOX 218 WESTBROOK, MN 56183		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 610	had received educa reporting and what neglect earlier in the she thought about the was agitated and has should have been r and tendency to real manner toward and go to the dining root had her eat in an an Review of the 12/28 Neglect-Rehab/Skill identified residents abuse, neglect, miss property and exploi subjected to abuse residents. Alleged of abuse were to be real administrator. If an allegation of abuse abuse of resident, the measures to proteo was to report the all an allegation of ress residents were to b both ensured a safe determine if a room made. The facility wassigned to complet care plan updated winto place. The investigations to the will be documented designated employed investigations to the	ation on Abuse, VA and constituted abuse and/or e month. LPN-A stated when the incident and knowing R1 ad the tendency to act out, she nore aware of R1's agitation act in a physically aggressive other resident and not had her im for the supper meal, but rea away from other residents.	F 61			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 27, 2022

Administrator Good Samaritan Society - Westbrook 149 First Street, Box 218 Westbrook, MN 56183

Re: State Nursing Home Licensing Orders Event ID: 3BD511

Dear Administrator:

The above facility was surveyed on January 12, 2022 through January 13, 2022 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

Good Samaritan Society - Westbrook January 27, 2022 Page 2

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.

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:

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504 Email: nicole.osterloh@state.mn.us Office: 507-476-4230 Mobile: (507) 251-6264 Mobile: (605) 881-6192

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.

Sincerely,

Kumala Piske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division

Good Samaritan Society - Westbrook January 27, 2022 Page 3 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minnesc	ta Department of He	alth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM				(X3) DATE COMP	SURVEY PLETED
		00082	B. W	/ING		01/1	C 3/2022
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS	S, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WESTBROOK	149 FIRST STR WESTBROOK,	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 00	00			
	****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORD	ER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has	issued on, it is cited violation dance rule of been tag below. ire to idered upon rule will the item				
	that may result fron orders provided tha the Department wit	hearing on any asses n non-compliance with t a written request is hin 15 days of receipt ent for non-compliance	n these made to of a				
	was conducted at y the Minnesota Depa facility was found N State Licensure. Pla plan of correction y and identify the date	TS: 1/13/22, a complaint our facility by surveyc artment of Health (ME OT in compliance wit ease indicate in your ou have reviewed the e when they will be co	ors from DH). Your h the MN electronic se orders				
	epartment of Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENT	ATIVE'S SIGNATUR	RE	TITLE		(X6) DATE

Electronically Signed

STATE FORM

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00082	B. WING			C 13/2022
	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
		149 FIRS	T STREET, BO			
GOOD S	AMARITAN SOCIETY	- WESTBROOK	ROOK, MN 561			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	The following complaint was found to be SUBSTANTIATED: H5595022C (MN79104) with a licensing order issued at 1980.					
	UNSUBSTANTIATE	laints were found to be ED: H5595023C(MN78385), 5595025C (MN74818).				
	The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state					
	tag number appear "ID Prefix Tag." The compliance is listed	ursing Homes. The assigned s in the far-left column entitled e state statute/rule out of I in the "Summary Statement				
	Comply" portion of a column also include violation of the state	umn and replaces the "To the correction order. This es the findings which are in e statute after the statement,				
	the surveyor 's find Method of Correction Correction.	et as evidence by." Following lings are the Suggested on and Time Period for				
	receipt of State lice the Minnesota Depa	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at				
	<https: www.health<br="">on/infobulletins/ib12 orders are delineate</https:>	n.state.mn.us/facilities/regulati 4_1.html> The State licensing ed on the attached Minnesota				
	you electronically. is necessary for Sta	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box				
	available for text. Ye electronic State lice heading completion	ou must then indicate in the ensure process, under the date, the date your orders wil o electronically submitting to	I			

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STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			A. DOILDING.			С
		00082	B. WING			13/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		ST STREET, BO ROOK, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	is enrolled in ePOC	artment of Health. The facility and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
21980	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 3 Reporting - Inerable Adults	21980			2/25/22
	reporter who has revulnerable adult is or who has knowled has sustained a phreasonably explained information to the conditional is a vulner the individual is a driven reporter is not required.	of report. (a) A mandated eason to believe that a being or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the common entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected e individual that occurred prior ss:	•			
	another facility and believe the vulnera previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above					
		s section requires a report of d maltreatment, if the reporter				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	·	SURVEY PLETED
		00082	B. WING	01/*	3/2022
AME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
SOOD S	AMARITAN SOCIETY		T STREET, E ROOK, MN 5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE
21980	Continued From pa	age 3	21980		
	been made to the o (d) Nothing in the reporter from also agency. (e) A mandated reason to believe to 626.5572, subdivise (5), occurred must subdivision. If the time believes that a agency will determ the reported error of the criteria under so 17, paragraph (c), facility may provid directly to the lead how the event meen 626.5572, subdivise (5). The lead age	on to know that a report has common entry point. is section shall preclude a reporting to a law enforcement reporter who knows or has hat an error under section ion 17, paragraph (c), clause make a report under this reporter or a facility, at any an investigation by a lead ine or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or e to the common entry point or agency information explaining ets the criteria under section ion 17, paragraph (c), clause ncy shall consider this naking an initial disposition of ubdivision 9c.			
	by: Based on interview facility failed to rep resident abuse to t timely manner for 2 Findings include: Review of the 1/13 identified an allega abuse occurred on was leaving the dir	ent is not met as evidenced and document review, the ort an allegation of resident to he State Agency (SA) in a 2 of 2 residents (R1 and R6). /22 at 3:58 p.m., SA report tion of resident-to-resident 12/19/21 at 5:20 p.m R6 ning room and passed by R1,		Administrator and interdisciplinary team will review policy and procedures regarding reporting of allegations of resident abuse, neglect, exploitation, or mistreatment at the 2/24/2022 QAPI meeting. R1□s allegation of abuse was reported on 1/13/2022. All other residents were reviewed to	
	behind R6 and stru	urposefully wheeled herself uck him on the back of the n hand. Staff then intervened		ensure if allegations of resident abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2	

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If continuation sheet 4 of 7

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		00082	B. WING			3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		T STREET, I OOK, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
21980	Continued From pa	ige 4	21980			
21960	to separate R6 and the facility notified t R6. Interview on 1/13/2 director of nursing of designee (SSD), id changes that occur mood changes resu directed toward sta happened to be clo occurred sporadica by environmental si included being in th and/or activities. R day sitting near the would became ang approached the des with other residents residents the DON incident dated 12/1 supper. R1 had str head as he was lea DON and SSD com provided to the adm members and the p been notified as ma been no "mental ar R6. Additional interview the DON identified practical nurse (LPI 12/19/21, who with and R6. LPN-A beli because, "she was	R1. There was no indication he SA of the abuse of R1 to 2 at 9:56 a.m., with both the (DON), and social services entified R1 had rapid mood red without warning. The ulted in anger and aggression ff and/or other residents that se to her . R1's behavior illy and seemed to be triggered timulation which at times had the dining room for meals 1 also spent a large part of her nursing station with staff, and ry if other residents sk or if staff were interacting s. When asked about any involving R1 and other and SSD identified the 9/21, which occurred during ruck R6 on the back of his twing the dining room. The firmed notification was ninistrator, DON, SSD, family provider, but the SA had not anagement believed there had aguish or harm", to either R1 or of on 1/13/22 at 2:50 p.m., with she contacted licensed N)-A who was working on essed the incident between R1 eved R1 intentionally hit R6 pretty over stimulated". The		 hours after the allegation is made events that cause the allegation in abuse or result in serious bodily in not later than 24 hours if the even cause the allegation do not involv and do not result in serious bodily the administrator or the facility an other officials. All staff will be educated by 2/25/2 regarding reporting of allegations resident abuse, neglect, exploitatimistreatment. Social Services Coordinator or dewill conduct audits weekly for one and monthly for two more months ensure allegations of resident abus neglect, exploitation, or mistreatmer reported immediately, but no later hours after the allegation is made events that cause the allegation in abuse or result in serious bodily in not later than 24 hours if the even cause the allegation do not involv and do not result in serious bodily administrator or the facility and to officials. Social Services Coordinator or dewill present findings of audits at m QAPI meetings for review and recommendations. Administrator will monitor compliations. 	nvolve njury, or its that e abuse r injury to d to 2022 of ion, or esignee month a to use, nent are than 2 if the nvolve njury, or its that e abuse r injury to other esignee nonthly	
innesota D	DON identified she agreement that R1	and the SSD were now in had intentionally turned in her behind R6, and struck him on				

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If continuation sheet 5 of 7

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00082	B. WING			C 13/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		T STREET, BC			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21980	Continued From pa	ige 5	21980			
	demonstrated inten	d. The DON stated R1 had It and the incident should have e SA as abuse within the e period.				
identified following administration, far residents physicia administrator was SA. Review of the 12/2 Neglect-Rehab/Sk identified residents abuse, neglect, m property and explo subjected to abuse residents. Alleged abuse were to be administrator. Des notified in accorda the SA if there was immediately but no allegation was ma The social worker	identified following administration, fam residents physician administrator was t	a., interview with LPN-A the incident, she notified ily members and each . The DON, SSD or o complete reporting to the				
	B/21, Abuse And lled, Therapy & Rehab policy have the right to be free from sappropriation of resident tation. Residents must not be by anyone, including, other or suspected violations of eported immediately to the gnated agencies were to be nee with state law, including an allegation of abuse, t later than two hours after the le and begin an investigation. or designated employee was to f all investigations to the SA fals within five working days of					
	administrator or dea policies or procedu of all allegations of appropriate timefra should re-educate s policies and proced of alleged abuse or	THOD OF CORRECTION: The signee could develop/revise res to ensure timely reporting abuse or neglect are within mes for reporting. The facility staff identified in the citation to lures, and audit all complaints neglect for a set determined those audits should be taken				

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TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00082	B. WING			C 13/2022
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY		T STREET, BO OOK, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 6	21980			
		l) committee to determine the nitoring or compliance.				
	TIME PERIOD FOR	R CORRECTION: 21 DAYS				
nesota De	epartment of Health					

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