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.

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

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WESTBROOK	**149 FIRST STREET, BOX 218 WESTBROOK, MN 56183**

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F 000	INITIAL COMMENTS On 1/12/22 through 1/13/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5595022C (MN79104), with deficiencies cited at F600, F609, and F610. The following complaints were found to be UNSUBSTANTIATED: H5595023C (MN78385), H5595024C (MN75091), and H5595025C (MN74818). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		2/25/22

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

Electronically 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.

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F 600	Continued From page 1 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 interview and document review, the facility failed to ensure residents were free from abuse for 1 of 1 resident (R6), who was willfully struck on the back of the head by R1. Findings include: Review of the 1/13/22 at 3:58 p.m., report to the State Agency (SA) identified an allegation of resident-to-resident abuse occurred on 12/19/21 at 5:20 p.m.. R6 was reported to be leaving the dining room and passed by R1, who turned and purposefully wheeled herself behind R6 and struck him on the back of the head with her open hand. Staff intervened and separated R6 and R1. R1's 11/4/21, quarterly Minimum Data Set (MDS) identified R1 had severe cognitive impairment, required limited assistance of one staff for locomotion and extensive assistance of one staff for all other activities of daily living. R1 used a wheelchair for mobility and was able to move independently as she wandered throughout the facility. R1's diagnoses included dementia, anxiety and depression. There were no behaviors documented during the assessment reference period. R1's current, undated care plan identified R1 had	F 600	Administrator and interdisciplinary team will review policy and procedures regarding resident abuse and neglect at the 2/24/2022 QAPI meeting. R6□s care plan updated on 1/20/2022 by DNS and Social Services Coordinator to ensure free from abuse by R1. All other residents care plans were reviewed and updated on 2/4/2022 by DNS and Social Services to ensure they are free from abuse, neglect, misappropriation of resident property and exploitation. All staff will be re-educated by 2/25/2022 regarding abuse and neglect. Social Services Coordinator or designee will conduct audits weekly for one month and monthly for two more months to ensure residents are free from abuse, neglect and exploitation. Social Services Coordinator or designee or designee will present findings of audits at monthly QAPI meetings for review and recommendations.	

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F 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. R6's undated, care plan identified a diagnosis of anxiety. R6 had a social personality and enjoyed/initiated social conversations with others. There was no mention of R6 being at high risk for further abuse by R1 or what interventions were needed to prevent further abuse. Observations on 1/12/22 from 10:00 a.m. to 2:00 p.m. identified R1 was able to wheel herself very quickly throughout the facility. R1 was unable to be interviewed when interview was attempted. Observation on 1/12/22, from 10:00 a.m. to 2:00 p.m. identified R6 was observed in his wheelchair, and independently wheeled himself from his room to the commons area and in the hall. R6 was observed speaking with residents and staff and was noted to ask repeated	F 600	Administrator will monitor compliance on this correction.	

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F 600	Continued From page 3	F 600		

questions.

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 afternoon and extending into the night), with outbursts of anger, and rapid mood changes from pleasant to angry and aggressive. Staff were aware and attempted to monitor and to keep her where they could monitor her. No other interventions were noted. LPN-B was unaware if any specific intervention was identified to safeguard R6 or other residents from R1's physical behaviors.

Interview on 1/12/22 at 1:26 p.m. with nursing assistant (NA)-A regarding R1 and R6 identified R1 had mood swings and without warning would become angry, clenched her fists, and would attempt to hit staff or "go after" other residents. R1 became "territorial" and did not want other residents to come close to the nurse's station. She would yell at other residents and tell them to "leave..they did not belong there". R6 was pleasant and tended to transport himself back and forth from his room to the common area. R6 enjoyed visiting with staff and other residents and had visited and even sat with R1 at times, but did have some cognitive issues and was known to repeatedly ask the same questions.

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F 600	Continued From page 4	F 600		

Interview on 1/12/22 at 2:37 p.m., with trained medication aide (TMA)-A identified R1 was usually seated by the nursing station to allow for staff monitoring, as she would yell at other residents who approached her to "get away!". Staff would immediately separate R1 from a situation at the nurses station to attempt to prevent escalation. TMA-A identified R1's behaviors occurred on a daily basis. She also wandered throughout the facility including into other resident spaces. R1 had a history of altercations with other residents, which usually occurred in the evening after supper due to "sundowning". TMA-A identified she was not 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 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

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F 600	Continued From page 5	F 600		

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 .

Additional interview on 1/13/22 at 2:50 p.m., with the DON identified she had contacted LPN-A who revealed she believed R1 had followed R6 as he went past and intentionally hit him on the back of his head. LPN-A had stated, "she did it on purpose as she was pretty over stimulated". After interviewing LPN-A, the DON determined R1 had intentionally followed after R6 and struck him on the back of the head. The DON agreed the facility should have reported the incident to the SA as abuse within the 2-hour time period. She had now reported the incident to the SA.

Interview on 1/13/22 at 4:00 p.m., with LPN-A identified the incident between R1 and R6 that took place in the dining room at approximately 5:20 p.m. on 12/19/21. LPN-A observed R1 was agitated prior to the supper meal due to stimulation that had started in the common area. R6 was going back and forth from his room to the common area. R1 had attempted to talk with R1 earlier. He continued to return and ask random questions to the nurses and to R1. R1 had become upset and expressed frustration by making physical and verbal expressions. R1 and R6 had been separated and redirected to the dining room for supper. At 5:20 p.m., R6 was

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F 600	Continued From page 6	F 600		

seen in his wheelchair leaving the dining room. R1 was seated in her wheelchair at her table. LPN-A observed R1 purposefully turn her wheelchair and roll up behind R6 who was passing by and strike him with an open hand to the back of his head. LPN-A immediately separated R1 and R6 at that time. R1 was upset and yelling at R6. R6 stated "Oww!" LPN-A identified notified the administrator, DON, SSD, the MD, and family members for both R1 and R6. LPN-A identified she had made the notifications, but had not reported to the SA as she understood that to be the responsibility of the administrative staff if that was necessary. LPN-A identified she had received education on Abuse, VA and reporting and what constituted abuse and/or neglect earlier in the month. LPN-A stated when she thought about the incident and knowing R1 was agitated and had the tendency to act out, she should have been more aware of R1's agitation and tendency to react in a physically aggressive manner toward another resident and not had her go to the dining room for the supper meal, but had her eat in an area away from other residents.

Review of the 12/28/21, Abuse And Neglect-Rehab/Skilled, Therapy & Rehab policy identified residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subjected to abuse by anyone, including, other residents. Alleged or suspected violations of abuse were to be reported immediately to the administrator. If an employee received an allegation of abuse, or witnesses suspected abuse of resident, the employee will take measures to protect the resident. The employee was to report the allegation to a supervisor. If it is an allegation of resident to resident abuse, the

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F 600	Continued From page 7 residents were to be separated immediately and both ensured a safe environment. Staff were to determine if a room change was needed to be made. Designated agencies were to be notified in accordance with state law, including the State Agency if there was an allegation of abuse, immediately but not later than two hours after the allegation was made. Staff were to notify the physician and family regarding the facts of the situation and inform them that an investigation is in progress. The facility would ensure someone was assigned to complete the investigation and the care plan updated with any new interventions put into place. The investigation was to include include interviewing employees, residents or other witnesses to the incident. The investigation will be documented. The social worker or designated employee will report the results of all investigations to the SA and and other officials within five working days of the incident.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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	F 609		2/25/22

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F 609	Continued From page 8 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 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 an allegation of resident to resident abuse to the State Agency (SA) in a timely manner for 2 of 2 residents (R1 and R6). Findings include: Review of the 1/13/22 at 3:58 p.m., SA report identified an allegation of resident-to-resident abuse occurred on 12/19/21 at 5:20 p.m.. R6 was leaving the dining room and passed by R1, who turned and purposefully wheeled herself behind R6 and struck him on the back of the head with her open hand. Staff then intervened to separate R6 and R1. There was no indication 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	F 609	Administrator and interdisciplinary team will review policy and procedures regarding resident abuse and neglect at the 2/24/2022 QAPI meeting. R6□s care plan updated on 1/20/2022 by DNS and Social Services Coordinator to ensure free from abuse by R1. Social Services Coordinator or designee will monitor interventions put in place to ensure solutions have been sustained. All other residents care plans were reviewed and updated on 2/4/2022 by DNS and Social Services Coordinator to ensure they are free from abuse, neglect, misappropriation of resident property and exploitation. All staff will be re-educated by 2/25/2022 regarding abuse and neglect. A RCA will be performed by the QAPI Committee by 2/25/2022.	

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F 609	Continued From page 9 happened to be close to her . R1's behavior occurred sporadically and seemed to be triggered by environmental stimulation which at times had included being in the dining room for meals and/or activities. R1 also spent a large part of her day sitting near the nursing station with staff, and would became angry if other residents approached the desk or if staff were interacting with other residents. When asked about any additional incidents involving R1 and other residents the DON and SSD identified the incident dated 12/19/21, which occurred during supper. R1 had struck R6 on the back of his head as he was leaving the dining room. The DON and SSD confirmed notification was provided to the administrator, DON, SSD, family members and the provider, but the SA had not been notified as management believed there had been no "mental anguish or harm", to either R1 or R6. Additional interview on 1/13/22 at 2:50 p.m., with the DON identified she contacted licensed practical nurse (LPN)-A who was working on 12/19/21, who witnessed the incident between R1 and R6. LPN-A believed R1 intentionally hit R6 because, "she was pretty over stimulated". The DON identified she and the SSD were now in agreement that R1 had intentionally turned in her wheelchair, moved behind R6, and struck him on the back of the head. The DON stated R1 had demonstrated intent and the incident should have been reported to the SA as abuse within the required 2-hour time period. 1/13/22 at 4:00 p.m., interview with LPN-A identified following the incident, she notified administration, family members and each residents physician. The DON, SSD or	F 609	Social Services Coordinator or designee will conduct audits weekly for one month and monthly for two more months to ensure residents are free from abuse, neglect and exploitation. Social Services Coordinator or designee or designee will present findings of audits at monthly QAPI meetings for review and recommendations. Administrator will monitor compliance on this correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. BUILDING _____ B. WING _____	C 01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WESTBROOK	**149 FIRST STREET, BOX 218 WESTBROOK, MN 56183**

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F 609	Continued From page 10 administrator was to complete reporting to the SA. Review of the 12/28/21, Abuse And Neglect-Rehab/Skilled, Therapy & Rehab policy identified residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subjected to abuse by anyone, including, other residents. Alleged or suspected violations of abuse were to be reported immediately to the administrator. Designated agencies were to be notified in accordance with state law, including the SA if there was an allegation of abuse, immediately but not later than two hours after the allegation was made and begin an investigation. The social worker or designated employee was to report the results of all investigations to the SA and and other officials within five working days of the incident.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 610		2/25/22

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F 610	Continued From page 11 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 appropriately investigate and identify new interventions following an allegation of physical abuse for 1 of 1 resident (R1). Findings include: R1's 11/4/21, quarterly Minimum Data Set (MDS) identified R1 had severe cognitive impairment, required limited assistance of one staff for locomotion and extensive assistance of one staff for all other activities of daily living. R1 used a wheelchair for mobility and was able to move independently as she wandered throughout the facility. R1's diagnoses included dementia, anxiety and depression. There were no behaviors documented during the assessment reference period. R1's current, undated care plan identified R1 had 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	F 610	Administrator and interdisciplinary team will review policy and procedures regarding investigation, preventing and correcting allegations of resident abuse, neglect, exploitation, or mistreatment at the 2/24/2022 QAPI meeting. R1□s allegation of abuse was investigated and new interventions were identified on 1/13/2022. All other residents were reviewed to ensure if allegation of abuse, neglect, exploitation or mistreatment appropriate investigation and new interventions are identified. All staff will be re-educated by 2/25/2022 regarding investigation, preventing, and correcting allegations of resident abuse, neglect, exploitation or mistreatment. Social Services Coordinator or designee will conduct audits weekly for one month and monthly for two more months to ensure allegations of resident abuse, neglect, exploitation or mistreatment are investigated, prevented and corrected. Social Services Coordinator or designee will continue to monitor that allegations of abuse, neglect, exploitation or mistreatment are investigated, prevented and corrected.	

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F 610	Continued From page 12 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. R6's undated, care plan identified a diagnosis of anxiety. R6 had a social personality and enjoyed/initiated social conversations with others. There was no mention of R6 being at high risk for further abuse by R1 or what interventions were needed to prevent further abuse. Observations on 1/12/22 from 10:00 a.m. to 2:00 p.m. identified R1 was able to wheel herself very quickly throughout the facility. R1 was unable to be interviewed when interview was attempted. Observation on 1/12/22, from 10:00 a.m. to 2:00 p.m. identified R6 was observed in his wheelchair, and independently wheeled himself from his room to the commons area and in the hall. R6 was observed speaking with residents and staff and was noted to ask repeated questions. 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 afternoon and extending into the night), with	F 610	Administrator will monitor compliance on this correction.	

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F 610	Continued From page 13	F 610		

outbursts of anger, and rapid mood changes from pleasant to angry and aggressive. Staff were aware and attempted to monitor and to keep her where they could monitor her. No other interventions were noted. LPN-B was unaware if any specific intervention was identified to safeguard R6 or other residents from R1's physical behaviors.

Interview on 1/12/22 at 1:26 p.m. with nursing assistant (NA)-A regarding R1 and R6 identified R1 had mood swings and without warning would become angry, clenched her fists, and would attempt to hit staff or "go after" other residents. R1 became "territorial" and did not want other residents to come close to the nurse's station. She would yell at other residents and tell them to "leave..they did not belong there". R6 was pleasant and tended to transport himself back and forth from his room to the common area. R6 enjoyed visiting with staff and other residents and had visited and even sat with R1 at times, but did have some cognitive issues and was known to repeatedly ask the same questions.

Interview on 1/12/22 at 2:37 p.m., with trained medication aide (TMA)-A identified R1 was usually seated by the nursing station to allow for staff monitoring, as she would yell at other residents who approached her to "get away!". Staff would immediately separate R1 from a situation at the nurses station to attempt to prevent escalation. TMA-A identified R1's behaviors occurred on a daily basis. She also wandered throughout the facility including into other resident spaces. R1 had a history of altercations with other residents, which usually occurred in the evening after supper due to "sundowning". TMA-A identified she was not

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F 610	Continued From page 14	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 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 .

Additional interview on 1/13/22 at 2:50 p.m., with the DON identified she had contacted LPN-A who

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F 610	Continued From page 15	F 610		

revealed she believed R1 had followed R6 as he went past and intentionally hit him on the back of his head. LPN-A had stated, "she did it on purpose as she was pretty over stimulated". After interviewing LPN-A, the DON determined R1 had intentionally followed after R6 and struck him on the back of the head. The DON agreed the facility should have reported the incident to the SA as abuse within the 2-hour time period. She had now reported the incident to the SA.

Interview on 1/13/22 at 4:00 p.m., with LPN-A identified the incident between R1 and R6 that took place in the dining room at approximately 5:20 p.m. on 12/19/21. LPN-A observed R1 was agitated prior to the supper meal due to stimulation that had started in the common area. R6 was going back and forth from his room to the common area. R1 had attempted to talk with R1 earlier. He continued to return and ask random questions to the nurses and to R1. R1 had become upset and expressed frustration by making physical and verbal expressions. R1 and R6 had been separated and redirected to the dining room for supper. At 5:20 p.m., R6 was seen in his wheelchair leaving the dining room. R1 was seated in her wheelchair at her table. LPN-A observed R1 purposefully turn her wheelchair and roll up behind R6 who was passing by and strike him with an open hand to the back of his head. LPN-A immediately separated R1 and R6 at that time. R1 was upset and yelling at R6. R6 stated "Oww!" LPN-A identified notified the administrator, DON, SSD, the MD, and family members for both R1 and R6. LPN-A identified she had made the notifications, but had not reported to the SA as she understood that to be the responsibility of the administrative staff if that was necessary. LPN-A identified she

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F 610	Continued From page 16	F 610		

had received education on Abuse, VA and reporting and what constituted abuse and/or neglect earlier in the month. LPN-A stated when she thought about the incident and knowing R1 was agitated and had the tendency to act out, she should have been more aware of R1's agitation and tendency to react in a physically aggressive manner toward another resident and not had her go to the dining room for the supper meal, but had her eat in an area away from other residents.

Review of the 12/28/21, Abuse And Neglect-Rehab/Skilled, Therapy & Rehab policy identified residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subjected to abuse by anyone, including, other residents. Alleged or suspected violations of abuse were to be reported immediately to the administrator. If an employee received an allegation of abuse, or witnesses suspected abuse of resident, the employee will take measures to protect the resident. The employee was to report the allegation to a supervisor. If it is an allegation of resident to resident abuse, the residents were to be separated immediately and both ensured a safe environment. Staff were to determine if a room change was needed to be made. The facility would ensure someone was assigned to complete the investigation and the care plan updated with any new interventions put into place. The investigation was to include include interviewing employees, residents or other witnesses to the incident. The investigation will be documented. The social worker or designated employee will report the results of all investigations to the SA and and other officials within five working days of the incident.

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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,

Kamala 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: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/12/22 through 1/13/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5595022C (MN79104) with a licensing order issued at 1980. The following complaints were found to be UNSUBSTANTIATED: H5595023C(MN78385), H5595024C and H5595025C (MN74818). 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter	21980		2/25/22

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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 TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 3 knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of resident to resident abuse to the State Agency (SA) in a timely manner for 2 of 2 residents (R1 and R6). Findings include: Review of the 1/13/22 at 3:58 p.m., SA report identified an allegation of resident-to-resident abuse occurred on 12/19/21 at 5:20 p.m.. R6 was leaving the dining room and passed by R1, who turned and purposefully wheeled herself behind R6 and struck him on the back of the head with her open hand. Staff then intervened	21980	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 ensure if allegations of resident abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2	

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21980	Continued From page 4 to separate R6 and R1. There was no indication 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 happened to be close to her . R1's behavior occurred sporadically and seemed to be triggered by environmental stimulation which at times had included being in the dining room for meals and/or activities. R1 also spent a large part of her day sitting near the nursing station with staff, and would became angry if other residents approached the desk or if staff were interacting with other residents. When asked about any additional incidents involving R1 and other residents the DON and SSD identified the incident dated 12/19/21, which occurred during supper. R1 had struck R6 on the back of his head as he was leaving the dining room. The DON and SSD confirmed notification was provided to the administrator, DON, SSD, family members and the provider, but the SA had not been notified as management believed there had been no "mental anguish or harm", to either R1 or R6. Additional interview on 1/13/22 at 2:50 p.m., with the DON identified she contacted licensed practical nurse (LPN)-A who was working on 12/19/21, who witnessed the incident between R1 and R6. LPN-A believed R1 intentionally hit R6 because, "she was pretty over stimulated". The DON identified she and the SSD were now in agreement that R1 had intentionally turned in her wheelchair, moved behind R6, and struck him on	21980	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 or the facility and to other officials. All staff will be educated by 2/25/2022 regarding reporting of allegations of resident abuse, neglect, exploitation, or mistreatment. Social Services Coordinator or designee will conduct audits weekly for one month and monthly for two more months to ensure allegations of resident abuse, neglect, exploitation, or mistreatment are reported immediately, but no 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 administrator or the facility and to other officials. Social Services Coordinator or designee will present findings of audits at monthly QAPI meetings for review and recommendations. Administrator will monitor compliance on this correction.	

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21980	Continued From page 5	21980		

the back of the head. The DON stated R1 had demonstrated intent and the incident should have been reported to the SA as abuse within the required 2-hour time period.

1/13/22 at 4:00 p.m., interview with LPN-A identified following the incident, she notified administration, family members and each residents physician. The DON, SSD or administrator was to complete reporting to the SA.

Review of the 12/28/21, Abuse And Neglect-Rehab/Skilled, Therapy & Rehab policy identified residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subjected to abuse by anyone, including, other residents. Alleged or suspected violations of abuse were to be reported immediately to the administrator. Designated agencies were to be notified in accordance with state law, including the SA if there was an allegation of abuse, immediately but not later than two hours after the allegation was made and begin an investigation. The social worker or designated employee was to report the results of all investigations to the SA and and other officials within five working days of the incident.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff identified in the citation to policies and procedures, and audit all complaints of alleged abuse or neglect for a set determined time. The results of those audits should be taken to the Quality Assurance Performance

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21980	Continued From page 6 Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		