DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 7, 2022

CMS Certification Number (CCN): 245149

Administrator
Good Samaritan Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 29, 2022 the above facility is certified for:

77 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 77 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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July 7, 2022

Administrator
Good Samaritan Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

RE: CCN: 245149
Cycle Start Date: March 31, 2022

Dear Administrator:

On April 15, 2022, we notified you a remedy was imposed. On May 4, 2022 the Minnesota Department of Health and on June 2, 2022 The Minnesota Departmant of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 29, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 30, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 15, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 31, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 29, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
April 15, 2022

Administrator
Good Samaritan Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

RE: CCN: 245149
Cycle Start Date: March 31, 2022

Dear Administrator:

On March 31, 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 delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 30, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 30, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 30, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 30, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Ambassador will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 30, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 30, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/28/22-3/31/22 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/28/22-3/31/22, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		4/29/22

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

Electronically Signed | 04/21/2022

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 554	Continued From page 1 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the process to determine self-administration and safe storage of medications was followed for 1 of 1 residents (R30), who was self-administering and storing medication. Findings include: R30's annual Minimum Data Set (MDS) indicated R30 had no cognitive impairment. R30's face sheet printed on 3/31/22, indicated diagnoses included arthritis. Facility assessment, Self-Administration of Medications (SAM) completed 2/9/22, noted R30 was able to continue to self-administer medication, but failed to indicate which medications R30 was able to self-administer. The assessment also failed to indicate if and how medications were stored in R30's room and if teaching or instruction was provided to R30. R30's care plan, printed on 3/31/22, noted R30 was able to safely administer nebulizers, nasal sprays, medicated shampoos and inhalers. R30's physician orders signed 3/3/22, included diclofenac sodium 1% gel (a non-steroidal anti-inflammatory medication), apply to hips and lower back three times daily for chronic pain,	F 554	On 3-30-2022 Medication was removed from R30 room and secured in a locked medication room. Self Administration of medication assessment was completed on 3-30-2022 and physician orders were obtained for self administration of medication. Care plan reviewed and updated Medical record reviews completed on residents who self administer medications to ensure proper assessment and physician order to support self administration of medications. Licensed Nurses will be educated 4/19/2022 through 4/29/2022 on facility policy and procedures for Resident self administration of medications including assessment, physician orders and need for medications to be secured if kept at bedside. Audits for R30 and 5 random residents whose self administer medications will be completed weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed by the Nurse Manager team for trends and/or patterns and implement improvement plans. Findings will be reported to the QA	

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F 554	Continued From page 2 however, did not include orders for self-administration. On 3/28/22, at 5:03 p.m. diclofenac sodium 1% gel was observed on a bay windowsill behind a recliner in R30's room. R30 stated she self-administered the medication to her hips as needed. R30 indicated staff assisted her to apply the medication to her back and were aware she kept the medication in her room. On 3/30/22, at 11:39 a.m. licensed practical nurse (LPN)-B stated R30 self-administered diclofenac gel and stored the medication in her room. Further, LPN-B stated a physician order was needed for residents to self-administer medications and confirmed there was none for R30. On 3/30/21, at 1:17 p.m. registered nurse (RN)-B reviewed R30's SAM and physician's orders. RN-B stated R30's SAM was incomplete and failed to indicate which medications R30 was able to self-administer or how they be securely stored in R30's room. Further, RN-B confirmed physician's orders did not include an order for self-administration. On 3/31/22, at 9:51 a.m. director of nursing (DON) stated self-administration of medication required a completed assessment and physician's order. Storage of medication in a resident's room required a lock box or another way for the medication to be securely stored. Facility policy, Resident Self-Administration of Medication- Rehab/Skilled reviewed/revised 10/15/21, directed prior to self-administration a SAM was completed and reviewed by the	F 554	committee for further evaluation and recommendations.	

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F 554	Continued From page 3 interdisciplinary team. A physician's order required a signature. Storage of medication in a resident's room required them to be secured.	F 554		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		4/29/22

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F 584	Continued From page 4 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident wheelchairs were in good repair for 1 of 1 residents (R27) whose wheelchair were observed to need repair. Findings include: R27's Face Sheet, undated, documented resident was readmitted 2/14/22 with the diagnoses of fracture of left femur neck with joint replacement surgery and fractures of lumbosacral spine and pelvis. R27's Admission minimum data set (MDS) dated 2/20/22, indicated R27 required extensive assistance with bed mobility, transfers, and dressing of 2-3 staff. He received occupational, physical and speech therapies. R27 was allowed minimal ambulation in room with the assist of one. The MDS indicated R27 was cognitively impaired. During observation on 3/28/22, at 5:00 p.m. R27's wheelchair had the following issues: > both WC arm rests soft pads had rippled cracked vinyl with the vinyl covering missing where the pad met the hard surface attached to the hard surface. The nylon webbing was exposed all the way around. > the left arm rest had approximately 4 inches	F 584	On 3-28-22, R27□s wheelchair was replaced by maintenance to a wheelchair in good working condition. Visual inspections were completed on all wheelchairs in facility and repairs/replacements made as appropriate. Education will be given to staff between 4/19/22 and 4/29/22 on proper wheelchair function and what to do when a wheelchair is no longer in good repair or needs to be replaced maintenance staff. Staff will be educated on when to notify maintenance through the maintenance log book when a wheelchair needs repair. Random audits of wheelchair condition will be completed by the maintenance department weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Maintenance Director or maintenance designee. Wheelchairs are put into open rooms as part of the cleaning process for new admissions. At this time, wheelchairs will be inspected and determined if in good repair or needs repaired. Results of audit will be reviewed by Maintenance team for trends and/or	

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F 584	Continued From page 5 wrapped in orange duct tape. > the sling back of the WC had two tears, one in the middle top and 1 next to the resident's right shoulder handle, each being approximately 1/2 inch each. During an interview on 3/28/22, at 5:00 p.m. R27 confirmed his wheelchair was provided by the facility. R27 stated he had been readmitted to the facility on 2/14/22, after being discharged to home two weeks earlier. While he was home, he fell and fractured his left hip. R27 stated this was the wheelchair he was provided upon admission, and was already in this condition. During interview on 3/30/22, at 1:20 p.m. licensed practical nurse (LPN)-A verified R27's wheelchair was provided upon admission. However, LPN-A stated she had not noticed the disrepair of both arms rests, the back rest nor the orange duct tape. LPN-A stated and had shown the log where resident equipment repair needs were logged by staff for maintenance to review and remove for repair. R27's wheelchair repair needs was not on the log. LPN-A stated that each day, maintenance rounded and collected the lists of things needing repair. In an interview on 3/30/22, at 1:34 p.m. maintenance director (MD) stated the maintenance department was unaware of R27's WC repair needs. MD verified the procedure facility staff were to follow, that of placing repair needs the repair logs found at each nurse's station, which maintenance reviews each day. MD stated that the facility did not have a specific policy for reporting repairs. MD stated the repair logs were the system the facility used for that purpose.	F 584	patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations.	

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure nails were trimmed and clean when a brown substance was under identiifed under the nails for 1 of 3 residents (R17) who were dependent on staff for activities of daily living (ADLs). Findings include: R17's annual Minimum Data Set (MDS) identified R17 required physical assistance from staff with ADLs including personal hygiene and did not refuse cares. R17's care plan printed 3/31/22, indicated he required maximum assist from another person to complete personal hygiene. R17's face sheet printed 3/31/22, included diagnosis diabetes mellitus (DM). On 3/28/22, at 2:35 p.m. R17 was observed to have ½ inch long fingernails, with dark brown, unknown substance under each nail on both hands. R17 stated, "they're pretty long and messy. It'd be nice to have them trimmed and cleaned." On 3/30/22, at 8:13 a.m. R17 was observed with ½ inch long fingernails, dark brown, unknown substance under each nail on both hands. R17	F 677	R17 fingernails were cleaned and trimmed by a Licensed Nurse on 3-30-2022. All residents were audited to ensure nails were trimmed and cleaned 3-31-2022 Nursing staff will be educated Nurse Managers on 4/18/2022 through 4/29/2022 on ensuring proper nail care for residents including routine trimming and cleaning of residents finger nails weekly and as needed. Random audits of resident finger nails to ensure cleaned and trimmed will be completed weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed by the Nurse Manager team for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations.	4/29/22

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F 677	Continued From page 7 was using his left hand to pick up pieces of fruit and place them in his mouth. On 3/30/22, at 11:44 a.m. licensed practical nurse (LPN)-B stated R17 required a nurse to cut and clean his fingernails because he had DM. Nurses cut and cleaned fingernails on bath day and as needed when they became soiled or were noted to be long. Further, aides were not allowed to clean fingernails of residents with a diagnosis of DM. On 3/30/22, at 1:40 p.m. registered nurse (RN)-B confirmed R17's fingernails, on both hands, were approximately ½ inch long with dark brown, unknown substance under each nail. RN-B stated she was aware R17 occasionally used his hands to bring food to his mouth. RN-B expected a nurse to cut and clean fingernails for residents with DM on their bath day and as needed, especially if a resident sometimes used their hand to bring food to their mouth. RN-B stated cut and clean nails prevented injury, possible infection and promoted dignity. On 3/31/22, at 9:55 p.m. director of nursing (DON) stated she expected nail care for residents with DM was completed by a nurse and was done weekly and as needed. She expected nails were observed daily for cleanliness, especially if we know they put their hands in their mouths. DON expected hand hygiene was provided before meals. Facility policy, Nail Care-Rehab/Skilled, Assisted Living, revised 3/8/2022, instructed licensed nurse should be notified to do nail care as needed for residents who are diabetic.	F 677		

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F 726	Continued From page 8	F 726		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure nursing staff had necessary competencies and skill set for indwelling catheters for 1 of 1 resident (R20).	F 726	R20 catheter tubing and drainage bag was replaced by RN on 3-31-2022. (NA)-C was educated on policy and procedure of infection control and catheter	4/29/22

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F 726	Continued From page 9 whom had an indwelling catheter. Findings include: R20's Minimum Data Set (MDS) dated 1/29/22, identified R20 was cognitively impaired and had an indwelling catheter. R20's diagnosis included neurogenic bladder and Parkinson's disease. R20's care plan revised on 3/1/22, identified R20 had an indwelling catheter. He was to wear a leg bag during the day and catheter drainage bag at night. The care plan further identified catheter care done by CNA (certified nursing assistant) with daily peri care (cleaning the private areas of a resident) and as needed. During an observation on 3/30/22, at 7:37 a.m. nursing assistant (NA)-C washed hands and put on clean gloves. NA-C gathered the supplies from the bathroom to switch from a catheter drainage bag to a leg bag. R20 was sitting on the edge of the bed and NA-C knelt to the catheter drainage bag and emptied the urine into a gradate (measuring devise). NA-C then put the drain spout in the holder without cleaning with an alcohol wipe. NA-C hooked the catheter drainage bag on the bed. NA-C then measured, emptied the graduate into the toilet and rinsed the graduate out. NA-C went back to R20, unhooked the catheter drainage bag from the side of the bed, disconnected the catheter drainage bag from the indwelling foley catheter tube, however, NA-C failed to use an alcohol wipe prior to disconnecting the catheter drainage bag from the indwelling foley catheter tubing. NA-C placed the catheter drainage bag on the floor with no cap on the open-ended tube. NA-C took the uncleaned leg bag with no cap on, attached it to the	F 726	cares, including handwashing, emptying of catheter bag, changing to leg bag and cleaning of catheter bag on 3-31-2022. (NA)-C was scheduled for additional day of orientation on 4-5-2022 to complete CNA pathway training packet All residents with leg bags were reviewed to ensure facility policy and procedure is being followed for care and handling. Nursing staff will be educated by Nurse Managers and complete competencies on 4/18/2022 through 4/29/2022 on GSS policy and procedure for catheter drainage bag emptying, changing of leg bags and straight drainage bags and proper cleaning of catheter bags. Observation Audits for R30 and 5 other random residents of catheter drainage bag emptying, changing of leg bags/straight drainage bags and cleaning of catheter bags will be completed weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed by the Nurse Manager team for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations.	

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F 726	Continued From page 10	F 726		

indwelling foley catheter tube and attached the leg bag to R20's leg. NA-C took off her gloves and finished getting R20 dressed and brought him to the bathroom where R20 washed his face and brushed his teeth. NA-C put on clean gloves, picked up the catheter drainage bag and brought it to the bathroom to place in a plastic bag hanging on a grab bar. NA-C straightened up R20's bed. NA-C went back into the bathroom, got the catheter drainage bag out of the plastic bag, uncapped a 60 cc (cubic centimeter) syringe out of a basin and an opened bottle of sterile water from a bathroom cabinet.

During an interview on 3/30/22, at 7:57 a.m. NA-C stated there was 25 cc of sterile water in the opened container. NA-C stated she could not find any vinegar to clean the catheter drainage bag with so I will use the sterile water and warm water from the tap.

Then NA-C took the 60 cc syringe, filled it with sterile water and put it in the catheter drainage bag tube and allowed the sterile water to go down the tubing to the catheter drainage bag, then swished it around and then drained it into the toilet. NA-C then got the graduate and put warm tap water into it and used the 60 cc syringe to get the warm tap water and put 60 cc of warm tap water into the catheter drainage bag and swished it around and then drained into the toilet. NA-A hung the drainage bag on the grab bar to allow to dry, there was no cap placed on the tubing that connected to the indwelling foley catheter. NA-C threw the plastic bag into the trash then tied up the garbage and linen bags and took gloves off. NA-C then brought them to the soiled utility room and washed her hands.

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During an interview on 3/30/22, at 8:03 a.m. NA-C stated this was her first NA job and was just off orientation. NA-C stated she was working independently but could ask questions of coworkers if she needed to. NA-C stated she had no orientation check list that needed to be completed for her to work independently. NA-C stated no one had shown her how to properly clean the catheter drainage bags, "so I do what is best for me". NA-C stated she would have used 40 cc to 50 cc of vinegar if she could have found the vinegar to clean out the catheter drainage bag. NA-C stated she should wash her hands and changed her gloves before and after cares. NA-C did not indicate any other times to wash hands and change gloves.

During an interview on 3/30/22, at 8:52 a.m. the director of nursing services (DNS) stated NA's have clinical instruction with an instructor, when done with clinical the NA students have orientation to the floor with a mentor. The DNS stated she was informed when the NA students were ready to go on the floor for training until they took their examination. The DNS stated the instructor updated her weekly and the NAs had eight to ten days of orientation on the floor with a mentor to learn the floor skills.

During an interview on 3/30/22, at 9:46 a.m. registered nurse (RN)-C visualized the catheter drainage bag in a plastic bag hanging on the grab bar in R20's room and stated there was no cap on the tip of the catheter drainage bag. RN-C stated the tip of the catheter drainage bag should be wiped with an alcohol wipe and the spout should be wiped with an alcohol wipe before placing in the holder. RN-C stated the catheter drainage bag should have been cleaned with a

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F 726	Continued From page 12 vinegar solution not just sterile water or tap water. During an interview on 3/30/22, at 11:36 a.m. the state nursing assistant coordinator (SNAC) stated new NAs had training in the lab and on the computer before they were able to be on the floor with a mentor. During an interview on 3/30/22, at 11:58 a.m. DNS stated NA-C did not have an orientation packet completed, nor was there any indication she was trained in changing from a catheter drainage bag to a leg bag. During an interview on 3/30/22, at 12:09 p.m. DNS stated NA-C should have used vinegar to clean the catheter drainage bag. DNS stated the catheter drainage bag should not have been on the floor, there should have been a cap on the end of the catheter drainage bag tubing, and NA-C should have changed gloves more frequently during the procedure. DNS stated R20 will need a new drainage system. During an interview on 3/30/22, at 1:13 p.m. the director of nursing services (DNS) stated she had no idea how NA-C slipped through the cracks for orientation. DNS stated NA-C had a mentor assigned to her for orientation, however, staffing did change at times and the facility would have more consistent mentors with orientees. During an interview on 3/31/22, at 8:30 a.m. staffing coordinator (SC) stated she put new employees on the schedule with a mentor. SC stated typically NA's have six to eight shifts with a mentor. SC stated my main goal was to make them comfortable before putting them on the floor.	F 726		

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F 726	Continued From page 13 A review of the facility General Unlicensed Pathway, Certified Nursing Assistant, Nursing Assistant-Certified revised 2/12/21, indicated competency was the ability to perform the skill safely, correctly, and effectively. Validation means the individual has demonstrated competence in the skill. -provides pericare and catheter care, handling and placing tubing appropriately to minimize infection. -for emptying catheter drainage bag/ leg bag appropriately to minimize infection/cross contamination. Document review revealed NA-C did not have this orientation check list completed. The facility policy Orientation dated 1/3/20, indicated the department/clinic was expected to provide learning options for employee competency/orientation achievement. The supervisor coordinates competency checklists in collaboration with the assigned preceptor. Completion of department /clinic orientation checklists were documented in the employee's department record.	F 726		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		4/29/22

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F 761	Continued From page 14 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to secure medications from unauthorized access on the TCU (transitional care unit) for 3 of 21 medication cupboards located in the xhallway of the TCU. This had the potential to affect all 21 residents on the TCU unit. Findings include: During an observation on 3/30/21, at 2:00 p.m. room 404's medication cupboard was unsecured with R122's medications inside. The unlocked cupboard contained several medications included but not limited to; Lisinopril 5mg (used for hypertension), metoprolol tartrate 50 mg (used for hypertension), seroquel PO 300mg at bed time (Antipsychotic). During an observation on 3/30/21, at 2:00 p.m. room 406's medication cupboard was unsecured	F 761	On 3-30-2022 upon further investigation Nurses noted lock was turning but not locking and maintenance was notified. Medications were removed from Medication cabinet and secured in locked cabinet. Maintenance noted the bolts on lock to be loose. Locks were tightened and medication cabinet was then secured and Nurses were able to lock. All medication cabinets were audited by nursing and maintenance staff on 3/31/22 and no other locks were noted to be loose or malfunctioning. Licensed Nurses will be educated by Director of Nursing 4/20/2022 through 4/29/2022 on policy and procedure of medication storage including safety check to ensure cabinet is locked and to move medications to a locked cabinet until lock	

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F 761	Continued From page 15 with R126's medications inside. The unlocked cupboard contained several medications included but not limited to; Potassium chloride ER 20meq dly (used to treat low potassium), dabigatran etexilate mesylate 150mg PO BID (used as a blood thinner) . During an observation on 330/22, at 2:01 p.m. room 415's medication cupboard was unsecured with R127's medication inside. The unlocked cupboard contained several medications included but not limited to; sotalol 80 mg dly (used to treat atrial fibrilation), torsemide 20mg po dly (used for hypertension), trazadone 50mg po qd (used to treat major depression), xarelto 20 mg dly (used to treat blood clots). During an observation and interview on 3/30/22, at 2:05 p.m. registered nurse (RN)-A checked medication cupboards for rooms 404, 406 and 415 and confirmed the medication cupboards were opened, not secured, and she locked them. RN-A state they should not be open. RN-A stated there were no narcotics stored in the medication cupboards and they were secured elsewhere on the unit. During an interview on 3/30/22, at 2:10 p.m. licensed practical nurse (LPN)-A stated she should have secured the medication cupboard for R126. LPN-A stated we know the medication cupboards need to be locked, I do not know what happened. During an interview on 3/30/22, at 2:16 p.m. LPN-C stated the medication cupboards should be locked. LPN-C stated I thought I locked R137's medication cupboard, it was a mistake. LPN-C stated the medication cupboards should	F 761	is repaired. Random audits of medication storage cabinets will be completed Nurse Managers weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed by the Nurse Manager team for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations.	

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F 761	Continued From page 16 be locked at all times. During an interview on 3/30/22, at 2:26 p.m. RN-D stated the medication cupboard for R122 should have been locked. RN-D stated the medication cupboards contained over the counter medications and scheduled medications but no narcotic medications. RN-D stated they needed to push in and turn the key to make sure it was locked. The facility policy Medications: Acquisition Receiving Dispensing and Storage dated 2/8/22, indicated medications will be stored in a locked medication cart, drawer, or cupboard. Only the person passing medications and the director of nursing services and/or designee will be permitted to have access to the keys to the medication storage areas.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		4/29/22

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F 880	Continued From page 17 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 18 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper catheter drainage bag care, hand hygiene, and glove use were followed for 1 of 1 resident (R20) observed during personal cares. Findings include: R20's Minimum Data Set (MDS) dated 1/29/22, identified R20 was cognitively impaired and had an indwelling catheter. R20's diagnosis included neurogenic bladder and Parkinson's disease. R20's care plan revised on 3/1/22, identified R20 had an indwelling catheter, was to wear a leg bag during the day and catheter drainage bag at night. The care plan further identified catheter care done by CNA (certified nursing assistant) with daily peri care (cleaning the private areas of a resident) and as needed. During an observation on 3/30/22, at 7:37 a.m. NA (nursing assistant)-C washed hands and put on clean gloves. NA-C gathered the supplies from the bathroom to switch from a catheter drainage bag to a leg bag. R20 was sitting on the edge of the bed, NA-C knelt to the catheter drainage bag and emptied the urine into a	F 880	R20 catheter tubing and drainage bag was replaced by RN on 3-31-2022. (NA)-C was educated on policy and procedure of infection control and catheter cares, hand hygiene, gloving, emptying of catheter bag, changing to leg bag and cleaning of catheter bag on 3-31-2022. All residents with leg bags were reviewed to ensure staff were following GSS policy and procedures for catheter cares. Nursing staff will be educated by Nurse Managers and complete competencies on 4/18/2022 through 4/29/2022 on policy and procedure of catheter drainage bag emptying, changing of leg bags and straight drainage bags and proper cleaning of catheter bags. Audits will be conducted for R30 and 5 random residents with catheters Nurse Managers for catheter drainage bag emptying, changing of leg bags/straight drainage bags and cleaning of catheter bags will be completed weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the	

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F 880	Continued From page 19 gradate (measuring devise). NA-C put the drain spout in the holder without cleaning with an alcohol wipe. NA-C hooked the catheter drainage bag on the bed. NA-C then measured, emptied the graduate into the toilet, and rinsed the graduate out. NA-C did not change her gloves or do hand hygiene. NA-C went back to R20, unhooked the catheter drainage bag from the side of the bed, disconnected the catheter drainage bag from the indwelling foley catheter tube. NA-C failed to use an alcohol wipe prior to disconnecting the catheter drainage bag from the indwelling foley catheter tubing. NA-C then place the catheter drainage bag on the floor with no cap on the open-ended tube. NA-C took the leg bag tubing tip, with no cap on, and no alcohol wipe used and attached the leg bag drainage system to the indwelling foley catheter tube. She attached the leg bag to R20's leg. NA-C removed her gloves, however, did not wash or sanitize her hands, and finished getting R20 dressed. NA-C brought R20 to the bathroom where he washed his face and brushed his teeth. NA-C put on clean gloves picked up the catheter drainage bag, brought it to the bathroom and placed in a plastic bag hanging on a grab bar. NA-C straightened R20's bed. NA-C went into the bathroom. NA-C did not change her gloves or do hand hygiene, and got the catheter drainage bag out of the plastic bag. Then NA-C got an uncapped 60cc (cubic centimeter) syringe out of a basin and an opened bottle of sterile water from a bathroom cabinet. During an interview on 3/30/22, at 7:57 a.m. NA-C stated there was 25 cc of sterile water in the opened container. NA-C stated she could not find any vinegar to clean the catheter drainage bag, and would use the sterile water and warm	F 880	Nurse Manager. Results of audits will be reviewed by the Nurse Manager team for trends and/or patterns and implement improvement plans. Findings will be reported to the QA committee for further evaluation and recommendations.	

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water from the tap.

NA-C took the 60cc syringe, filled it with the sterile water and put it in the catheter drainage bag tube and allowed the sterile water to go down the tubing to the catheter drainage bag. She swished it around and then drained it into the toilet. NA-C put warm tap water into the graduate, used the 60cc syringe to get the warm tap water to put into the catheter drainage bag and swished it around. She then drained into the toilet. NA-A hung the drainage bag on the grab bar to allow to dry, there was no cap placed on the tubing that connected to the indwelling foley catheter. NA-C threw the plastic bag into the trash then tied up the garbage and linen bags. She removed her gloves. NA-C then brought the bags to the soiled utility room and washed her hands.

During an interview on 3/30/22, at 8:03 a.m. NA-C stated she was working independently but could ask questions of coworkers if she needed to. NA-C stated no one had shown her how to properly clean the catheter drainage bags, "so I do what is best for me". NA-C stated she would have used 40cc to 50cc of vinegar if she could have found the vinegar to clean out the catheter drainage bag-remove. NA-C did not look or ask where the vinegar was located. NA-C stated she should wash her hands and changed her gloves before and after cares. NA-C did not indicate any other times to wash hands and change gloves.

During an interview on 3/30/22, at 8:52 a.m. the director of nursing services (DNS) stated NA's have clinical instruction and then orientation to the floor with a mentor. The DNS stated she was informed when the NA students were ready to go

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on the floor for training until they took their examination. The DNS stated the instructor updated her weekly and the NAs had eight to ten days of orientation on the floor with a mentor to learn the floor skills. DNS stated NA-C was orientated on a different unit that did not have urinary catheters.
During an interview on 3/30/22, at 9:46 a.m. registered nurse (RN)-C visualized the catheter drainage bag in a plastic bag hanging on the grab bar in R20's room and stated there was no cap on the tip of the catheter drainage bag. RN-C stated the tip of the catheter drainage bag should be wiped with an alcohol wipe and the spout of the catheter drainage bag should be wiped with an alcohol wipe before placing in the holder. RN-C stated the catheter drainage bags were cleaned with a vinegar solution, not just sterile water or tap water. RN-C stated there are caps for the catheter tubing at the nurse's station.

During an interview on 3/30/22, at 11:36 a.m. the state nursing assistant coordinator (SNAC) stated new NAs had training in the lab and on the computer before they were able to be on the floor with a mentor.

During an interview on 3/30/22, at 12:09 p.m. DNS stated NA-C should have used vinegar to clean the catheter drainage bag. DNS stated the catheter drainage bag should not have been on the floor, and there should have been a cap on the end of the catheter drainage bag tubing. DNS stated NA-C should have changed gloves more frequently during the procedure, R20 required a new drainage system.

The Catheter Bag Cleaning section of the policy directed staff to assemble equipment. Knock on

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F 880	Continued From page 22 the door. Identify the resident. Explain the procedure and proved privacy. Perform hand hygiene and apply gloves. Empty the large drainage bag. Clamp the catheter tubing. Disconnect the urinary catheter tube from the large bag. Do not pull on catheter. Place the large bag on a towel or in a basin. Clean the tip of the leg bag with an alcohol pad, wiping away from the opening. Attach the leg bag to the catheter tubing. Store tubing caps in designated bag or container when not in use and clean tubing inside and out with alcohol pad before recapping tubing. To clean the bag not in use: Rinse the bag with warn soapy water or bacteriostatic solution such as one part vinegar and three parts water solution or an appropriate commercial solution. Pour solution into the bag. Swish the solution around being sure to get the corners of the bag. Hint: 60cc syringe may be used to get solution into bag, be sure to clean the tip of the syringe with alcohol wipe before use and store in clean dry place. Soak the bag for 30 minutes. Open the bottom drainage port and drain the solution from the bag. Rinse the bag with warm water and hang to dry in the resident's restroom covered with a clean towel. Cover/cap the tubing one the bag is dry. Remove gloves if applicable. Perform hand hygiene. Leave resident comfortable. Place call light within reach. Document where/when appropriate.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/29/2022. At the time of this survey, Good Samaritan Ambassador was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 04/25/2022

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society Ambassador Building 01 is a 1-story building with a partial basement. The building was constructed at three different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) construction. In 2010, an addition was constructed and was determined to be of Type V (111) construction. There is a 2-hour firewall between the 2010 addition and the rest of the	K 000		

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K 000	Continued From page 2 building. Therefore, the facility was surveyed as two separate buildings. The building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Since Type V(111) construction is allowed for a 1-story building, the entire building will be surveyed as Type V(111). The facility has a capacity of 77 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		4/29/22

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K 353	Continued From page 3 by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 4.1.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/29/2022, between 10:30 AM and 12:30 PM, observation revealed that suspended ceiling tiles were missing in Room A-3, Room A-6, and the hallway near the HIM office. An interview with the Administrator verified is finding at the time of discovery.	K 353	On 3/29/22, maintenance team replaced the missing ceiling tiles in the following rooms; A-3, A-6, and in the hallway by the Health Information Office. An audit was conducted on 3/29/22 of the entire building to ensure that all ceiling tiles were in place. Maintenance staff will be educated between 4/20/22 and 4/29/22 on the process of replacing missing ceiling tiles when they are taken down or when they are damaged. Visual inspection of ceilings will be completed by Maintenance staff weekly for the first month, monthly for 3 months, and quarterly thereafter as coordinated by the Maintenance Director. Results of the audit will be reviewed by the maintenance team for trends and patterns and implement improvement ideas. Findings will be reported to the QA committee for further evaluation and recommendation.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible	K 712		4/29/22

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K 712	Continued From page 4 alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/29/2022, between 10:30 AM and 12:30 PM, a review of the available documentation revealed that the fire drill reports provided no evidence of drilling being conducted for the 2nd shift during the 4th quarter of 2021. An interview with the Maintenance Director verified this finding at the time of discovery.	K 712	K712 1. Accept this as the facilities credible allegation of compliance and correct citation K712. 2. The Maintenance Director will be responsible for scheduling and ensuring completion of quarterly fire drills per facility policy. 3. Facility Safety Committee will review and oversee completion and documentation that all quarterly fire drills are completed. 4. The facility administrator will be responsible for the corrective actions and monitoring of compliance. 5. The make-up fire drill will be completed on/by 4/29/22.	