DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2020

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: CCN: 245558
Cycle Start Date: June 24, 2020

Dear Administrator:

On July 16, 2020, we notified you a remedy was imposed. On August 11, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 31, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 31, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 16, 2020, 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 July 31, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 31, 2020, 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 Therefore, the NATCEP prohibition is rescinded.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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
July 16, 2020

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

RE: CCN: 245558
Cycle Start Date: June 24, 2020

Dear Administrator:

On June 24, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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 July 31, 2020.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 31, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 31, 2020.

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 a civil money penalty (42 CFR 488.430

through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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 $10,483; 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 July 31, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Windom will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 31, 2020. 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" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784

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 December 24, 2020 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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/23 and 6/24/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: #H5558023C with a deficiency issued at F684. In addition, as a result of investigation a deficiency was identified at F880. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		7/31/20

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

Electronically Signed | 07/24/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement interventions for 1 of 1 resident (R1), who experienced a fall with injury. R1 sustained actual harm, a subdural hematoma and pelvic fracture resulting in a discomfort and a decline in mobility. Findings include: R1's admission record indicated the resident was admitted to the facility on 2/8/19. R1's diagnoses record identified current diagnoses to include: Alzheimer's disease, osteoarthritis, hemiarthroplasty of the left hip, essential hypertension and diabetes mellitus type 2. Review of R1's quarterly Minimum Data Set (MDS) assessment dated 5/15/20, identified R1 as having a brief interview for mental status (BIMS) score of "7" (indicating R1 had moderately impaired cognition). The MDS indicated R1 was independent with bed mobility and transfers with set up assistance only. The MDS also indicated R1 was independent with ambulating in room with set up assistance and ambulated in the corridor with staff supervision, and a walker for ambulation. Further, the MDS indicated R1 was independent with toileting, and exhibited no impairment in range of motion (ROM) to the upper or lower extremities. During observation on 6/23/20, at 10:30 a.m. R1 was resting in bed. R1 was observed to be repositioned by staff while in bed. R1 offered no complaints during the care, but stated she wanted to go home. R1's left eyebrow was slightly	F 684	F-684 Corrected Date: July 31, 2020 It is the current policy and procedure of GSS-Windom to provide quality care to all clients. R1 went to the hospital on June 17, 2020 and returned to the facility on June 19, 2020. While R1 was hospitalized, a palliative medicine consult for clarification of goals of care and recommendations for symptom management/anticipated symptom management was completed. Upon return, hospice services were initiated, which currently includes a weekly RN visit. Additionally, the physician of record did a follow-up visit with R1 at the facility on July 8, 2020. Current treatment includes scheduled and PRN pain medicine. R1's care plan was updated on June 20, 2020. All residents with falls in the past 60 days are at potential risk for this deficient practice. These residents will be reviewed for initiation and completion of appropriate assessments to meet their needs and provide them quality care by July 31, 2020. Any care plans will be updated as appropriate. New falls will be reviewed M-F to ensure proper assessment and interventions are completed. New falls with injury occurring on the weekend/holiday will be reported to the Director of Nursing or designee for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2 swollen and bluish in color. Review of an incident report dated 6/17/20, at 5:00 a.m. indicated R1 experienced an unwitnessed fall in her room. The report indicated R1 alerted staff she had fallen by yelling out loudly. R1 was found laying on her right side on the floor. The report indicated R1 stated she was attempting to go to the bathroom when she fell. R1 was incontinent and obtained a laceration to the outer left eyebrow that was swollen and bleeding. The laceration was identified a s measuring 3.0 centimeters (cm). Steri-strips and an ice pack were applied to control the bleeding, R1 complained of pain when touched. R1 had previously been independent with ambulating and toileting. The report further indicated R1 had no other injuries or complaints when assessed. Neurological checks were initiated. Review of R1's medical record included neurological checks on 6/17/20, at 5:30 a.m., 5:37 a.m., 6:05 a.m. and 9:13 a.m. 5:36 a.m. vital signs (VS) and neurological assessment (neuro) = within normal limits (WNL). Pain = 0 (pain scale of 1-10 meaning 1 mild and 10 severe). Eyebrow laceration oozing blood. Ice Pack applied. 5:37 a.m. VS and NA = WNL. Pain = 1 6:05 a.m. VS and NA= WNL. Pain=0. Slight oozing of blood from eyebrow laceration. 9:13 a.m. VS and NA = right leg and left leg weak. Pain =1. No action was taken when R1 was identified with weakness in the lower extremities with pain. The progress note indicated R1 was having difficulty standing and required extensive assistance to the toilet. A mechanical lift was required. The note also indicated R1's left	F 684	To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursing and the Clinical Learning, and Development Specialist by July 31, 2020 regarding the policy and procedures for monitoring neurological checks and assessments, as well as the change in condition UDA and pain UDA. Education will include the critical importance of completing comprehensive assessments, expected monitoring in accordance with INTERACT tools, and appropriate interventions. Additional education and monitoring will be provided for CM-1 regarding critical thinking skills needed for quality assessment by July 31, 2020 and on-going. The citation will be reviewed at the July 29, 2020 QAPI meeting with a Mini Model for Improvement initiated as appropriate. An audit of residents with falls and the completion of assessments and data collection tools based on policy and procedure will be conducted by the Director of Nursing Services or designee, weekly for 12 weeks. All audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3	F 684		

eyebrow laceration continued to bleed and R1 was refusing to eat.

There were no further VS or neuro checks completed after 9:13 a.m. when R1 exhibited signs of a change in condition. The medical record indicated R1 was given scheduled Tylenol at 7:39 a.m. There was no offer of pain medication at any other time.

R1's post fall progress notes were reviewed for 6/17/20:

At 6:04 a.m. an entry indicated R1 was resting in bed, denied complaints of pain and an ice pack was applied to the left side of the forehead. R1's laceration on the forehead was described in the notes as having 10 cm of blood from the area.
At 7:39 a.m. an entry indicated R1 required assistance of a pivot transfer to wheelchair when assisted to the bathroom. The note further indicated R1 had no complaints.
At 9:20 a.m. an entry indicated a fax was sent to the provider indicating R1 had a fall and obtained a 3.0 cm laceration on the left outer eyebrow. Steri-strips and an ice pack were applied with no other injuries noted. (There was no return fax from the provider verifying notification).
At 9:24 a.m. an entry indicated R1 was attempting to get out of bed but required extensive assistance of staff to the toilet. R1's laceration on the left eyebrow was described as bleeding, and the note indicated a new pressure dressing was applied to control the bleeding. R1 refused breakfast when offered. The note further indicated R1 had trouble standing during assistance to the toilet and a standing lift was needed.
At 10:36 a.m. an entry indicated R1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET WINDOM, MN 56101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4	F 684		

scratching at the laceration on her left eyebrow and causing it to bleed more.
At 11:53 a.m. an entry indicated R1's eyebrow laceration continued to bleed and new steri-strips and pressure dressings were applied.
At 11:55 a.m. an entry note indicated there was increased bleeding from R1's laceration on the left eyebrow and another pressure dressing was applied due to saturation of blood. The note further indicated R1 had blood under her fingernails and may have been scratching at the laceration.
At 12:20 p.m. an entry indicated R1 refused to eat dinner when offered.
At 12:42 p.m. an entry indicated the laceration over R1's left eye continued to ooze blood and the eye was swollen shut. The facility's physician assistant (PA) was notified and indicated she would provide a house visit to assess the resident.
At 1:03 p.m. an entry indicated the facility PA assessed R1 and ordered a transfer to the emergency department (ED) by ambulance for further evaluation of the head wound and left hip pain.
At 2:24 p.m. an entry indicated a nurse from the ED informed the facility R1 was being transferred to the Mayo hospital in Mankato MN for further treatment, due R1 having a subdural hematoma and pelvic fracture.

A summary of the progress notes indicated R1 had a change in condition at 9:24 a.m. when R1 had difficulty standing and required extensive assistance of staff to the toilet, requiring a mechanical lift. R1 had previously been independent with mobility. R1's laceration on the left eyebrow continued to bleed requiring continued pressure and the resident was refusing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5	F 684		

to eat. The medical record did not include a thorough evaluation/assessment of R1's decline in condition or weakness, nor did it include a pain assessment to include thorough monitoring of R1's left hip pain or control.

Review of the PA visit progress note dated 6/17/20, at 1:00 p.m. indicated the PA was notified by facility staff R1 had fallen and had become more lethargic since the fall. The PA stated she was told by staff R1 was previously independent with mobility, but since the fall had been in bed and now required total assistance. The PA indicated she was informed R1 refused to eat or drink all day other than a sip of water taken with her medications at 9:00 a.m. on 6/17/20. The PA stated facility staff had further informed her they'd been unable to control the bleeding from R1"s left eyebrow laceration after the fall, even when applying pressure. The PA also stated she was informed R1 had complained of nausea right after the fall, and stated the staff had reported they'd changed the pressure dressing to the resident's left eyebrow laceration 3-4 times throughout the day and could not obtain homeostasis. The PA indicated R1 had also reported left hip pain. Review of the 6/17/20 physical exam results by the PA, indicated R1 was identified to be lethargic and moaning in pain. R1 responded but did not open her eyes during the exam. The laceration on R1's left eyebrow was actively bleeding and swollen with an obvious hematoma formation. Finally the PA's note indicated R1 was to be transferred by ambulance to the ED for further evaluation.

Review of an ED progress note dated 6/17/20, at 2:20 p.m. indicated R1 was examined after arrival to the ED. R1 continued to have bleeding from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 6	F 684		

the facial laceration as well as moderate complaints of left hip pain. A computed tomography (CT) scan of the head was ordered with findings of an acute cerebral convexity subdural hematoma with periorbital soft tissue swelling. A CT scan of the pelvis was ordered with findings of an acute minimally displaced fracture of the left pubic body. The ED progress note indicated R1 would be transferred to the Mayo hospital in Mankato MN for further evaluation and treatment.

Review of a Mayo hospital discharge summary note dated 6/19/20, indicated R1's fractured pelvis and subdural hematoma were evaluated and it had been determined R1 was a high risk surgical candidate and therefore surgery was not recommended. R1's family chose comfort care measures only and R1 was discharged back to the nursing home facility with hospice care services

During an interview on 6/23/20 at 11:45 a.m., case manager (CM)-A stated she provided care for R1 after the fall. CM-A stated she felt R1 was stable until around 11:30 a.m., when R1's eyebrow laceration continued to bleed. CM-A further stated she felt R1's condition had not changed enough to warrant notification of the provider until that time. CM-A stated, "Although [R1's] laceration on the eyebrow continued to bleed, [R1's] neuro and VS were within normal limits even though a change in [R1's] mobility had been identified by a nursing assistant at 9:13 a.m.." CM-A confirmed R1 had been independent with mobility before the fall and at 9:13 a.m. on 6/17/20, R1 could not bear weight requiring a mechanical lift for transfers. CM-A also confirmed R1 had periods of left hip pain, but felt it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7	F 684		

minimal. CM-A stated she'd only called the physician assistant (PA) because she thought R1's laceration needed stitches to stop further bleeding.

During interview on 6/23/20 at 11:30 a.m., nursing assistant (NA)-A and NA-B stated they had both provided care for R1 on 6/17/20, after the fall. NA-A and NA-B stated R1 started to complain of left hip pain around 8:30 a.m. when repositioned in her bed. NA-A and NA-B said R1 was weak and required total assistance with all activities of daily living (ADL's) that included mobility. NA-A and NA-B confirmed R1 had been independent with mobility prior to the fall. NA-A and NA-B further indicated R1's laceration on the left eyebrow continued to swell and bleed through several pressure dressings throughout the morning. NA-A and NA-B further added R1 had been sleepier, refused to eat and stayed in bed all morning. NA-A and NA-B both stated they reported R1's changes in condition to CM-A when identified.

According to interview with registered nurse (RN)-A on 6/23/20 at 2:45 p.m., RN-A confirmed she'd provided care for R1 at the time of the fall. RN-A stated she assessed R1 and did not identify any injuries other than a 3.0 cm laceration above the left eye, that was noted to be bleeding slightly. RN-A stated R1 denied complaints of pain when RN-A evaluated R1's extremities, adding that R1 was alert and she didn't note any change in cognition. RN-A further indicated a mechanical lift was used to transfer R1 back into bed per protocol. RN-A stated she was unsure whether R1 could bear any weight at that time because they did not attempt to have R1 bear any weight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8	F 684		

When interviewed on 6/23/20 at 3:00 p.m., the facility's physician assistant (PA) confirmed the above documented dictated notes from the visit she made for R1 on 6/17/20. The PA stated when she examined R1 there was blood all over the resident's face, neck and upper body from the laceration on the left eyebrow, and the left eye was swollen shut. The PA stated there was a lot of bleeding from the laceration making it difficult to see the depth of the wound. The PA further indicated R1 was moaning in pain during attempts to sit her up in bed. The PA stated she assessed R1's extremities and the resident complained of left hip pain with range of motion (ROM). The PA further reported staff had informed her R1 had been more lethargic and weak, and the dressing on the eyebrow had required several dressing changes over the prior hour, due to increased bleeding and saturation of the dressings. The PA stated she should have been notified sooner when the resident's condition was noted to have changed. Changes that included not bearing weight and requiring a mechanical lift for transfers, pain in the left hip area, and the uncontrolled bleeding from the laceration on the left eyebrow were significant, and the PA stated earlier treatment could have prevented or decreased discomfort for R1.

The director of nursing (DON) and administrator were interviewed on 6/24/20 at 1:00 p.m., and reviewed the record with the surveyor. They confirmed R1's condition had declined after the fall. The DON stated staff had not implemented the facility's policy/guidelines for monitoring neurological checks/assessments, nor had the staff completed the facility's change in condition checklist, or provide interventions to provide comfort for R1. The DON and administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9 verified the medical provider should have been contacted to provide direction related to changes observed for the resident. The facility's procedure Neurological Evaluation revised 1/20, indicated staff were to complete a neurological evaluation when a resident had an unwitnessed fall, or following an event that results in a known or suspected head injury. The procedure included: Initiate and document a baseline neurological evaluation after the incident, notify the provider of the event and findings of the evaluation, obtain orders for subsequent neurological evaluations or other medical care, after the completion of the initial neurological evaluation with vital signs, continue with evaluations every 30 minutes for 4 times, then every 8 hours for 3 days or as directed by the provider. The policy further included: Evaluate and compare subsequent neurological evaluations to the initial baseline and previous evaluations and notify the provider of any neurological findings, which are a change from the baseline or previous evaluations. The facility's procedure for Change in Condition Evaluation revised 5/16/20, directed staff to complete a change in condition checklist to improve communication between nurses and the provider when nursing was monitoring a change in condition, and to enhance the nursing evaluation and documentation of a resident who has a change in condition. The procedure indicated the evaluation would provide a standard format to collect pertinent clinical data prior to contacting the provider when there was a change in condition.	F 684		
F 880	Infection Prevention & Control	F 880		7/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880 SS=F	Continued From page 10 CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

§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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 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. §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 follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing preventive measures to prevent the spread of COVID-19. This had the potential to affect all 61 residents who resided at the facility. Finding include:	F 880	F-880 Corrected Date: July 31, 2020 It is the current policy and procedure of GSS-Windom to follow appropriate infection control practices in accordance with policy and procedure, as well as state and federal regulations. All residents were re-educated on wearing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 During an observation on 6/24/20, at 11:00 a.m. licensed practical nurse (LPN)-A was in the nurses' station without a facemask, preparing to give a resident medication. The resident was approximately one to two feet away from LPN-A and was also unmasked. LPN-A stated when he is at the nurses' station he is not required to wear a facemask, and further stated he got too hot wearing the mask. During an observation on 6/24/20, at 11:15 a.m. activity assistant (AA)-A was in the lounge sitting within a foot of a resident reading a book. AA-A was not wearing eye protection. AA-A stated she was not required to wear eye protection, except when feeding a resident. During an interview on 6/24/20, at 11:30 a.m. the activity department director (AD)-B confirmed activity staff were only required to wear eye protection when feeding a resident. During an observation and interview on 6/24/20, at 11:40 a.m. registered nurses (RN)-B and (RN)-C were in the nurses' station, not wearing facemasks or eye protection. The nurses' station was open to the unit, having only two walls and one counter-height peninsula. During the observation, residents self-propelled or walked within six feet of these staff. RN-B and RN-C stated they were not required to wear a facemask or eye protection at the nurses' station. During an observation and interview on 6/24/20, at 11:45 a.m. R1 was seated in the north dining room with other residents, eating lunch. R1 was on day five of a 14 day quarantine after returning from the hospital on 6/19/20. Registered nurse (RN)-A stated that R1 was considered to be in the	F 880	face masks the week of June 29, 2020. At this time also, bags containing face masks were provided to each client to facilitate the use of them. All resident care plans were updated, as appropriate, for each client the week of June 29, 2020. All staff will continue to encourage residents to wear their masks. Management will provide ongoing education to the residents, as needed, to encourage the wearing of masks by residents. Throughout the pandemic, new admissions will be educated, assessed, and care planned for their individual needs regarding face mask wearing. To prevent further potential deficient practice, immediate staff education was provided concerning 3 topics: encouraging residents to wear face masks, the appropriate wearing of PPE by all staff in resident areas, and clarification of Gray Zone PPE requirements. All staff will be further educated by the Director of Nursing and Infection Preventionist by July 31, 2020, regarding the appropriate usage and wearing of PPE for both residents and staff, based on current policy and recommendations. Throughout the pandemic, all new staff will be trained on these same topics. The gray zone PPE and signage requirements were updated to include gown usage. Surveyors re-educated management on the MN DOH requirements and provided information as requested by management. As the pandemic situation evolves,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 "gray zone" per the facility cohort plan. RN-A stated R1 was not confined to her room for the 14 day quarantine period and while staff were required to wear a facemask, eye protection, and gloves when caring for R1, a gown was not required. During an observation on 6/24/20, at 12:05 p.m., residents were observed self-propelling in hallways without masks. During an interview on 6/24/20, at 12:10 p.m. in her room, R4 stated "we're not required to wear a mask here unless we leave for an appointment." During an interview and observation on 6/24/20, at 12:20 p.m. the director of nursing (DON) stated residents wear a mask when they leave their room "if they want to." The DON further stated residents are asked at the time of admission if they want to wear a mask. The DON was observed wearing her personal eye glasses with detachable eye shields on each side, for eye protection. During an observation and interview on 6/24/20, at 12:45 p.m. RN-A was sitting at the nurses' station with her mask off, interacting with a staff person who was one to two feet away. RN-A stated staff were not required to wear facemasks while at the nurses' station. On 6/24/20 at 12:50 p.m., R1 was observed resting in her room on the north end of the facility. There were no signs outside her door indicating she was in quarantine and no cart outside her room for personal protective equipment (PPE). During an observation on 6/24/20, at 12:55 p.m. nursing assistant (NA)-A was feeding two	F 880	management will continue to participate in available education opportunities. The citation will be reviewed at the July 29, 2020 QAPI meeting with a Mini Model for Improvement initiated as appropriate. An audit of residents and staff members wearing PPE as appropriate will be conducted by the Quality Coordinator or designee, 5 times per week, on various shifts for 12 weeks. A combination of observation and knowledge verification will be used. All new staff will have a competency completed to verify PPE knowledge and skill. All audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14	F 880		

residents at a dining table with her facemask below her nose. NA-A stated it was hard to breathe with her mask on, so she put it below her nose at times.

During an interview on 6/24/29, at 1:00 p.m. the administrator stated R1 was not quarantined, and stated the facility was using guidance from their corporation to determine which residents required quarantine. The administrator said R1 did not meet quarantine criteria therefore staff were not required to wear gown and gloves when entering R1's room to provide care.

During an interview on 6/24/20, at 1:15 p.m. DON stated she thought residents could be asked if they wanted to wear a mask. The DON stated residents are offered masks weekly, but have the option to refuse. Further, the DON stated it was acceptable practice for staff to remove their eye protection and/or mask when at the nurses' station when not providing direct care to a resident. The DON stated staff were required to wear a facemask and eye protection when feeding a resident.

Facility policy titled Infection Prevention, revised date 6/16/20, indicated:
1. Purpose was to provide guidance to healthcare personnel working in healthcare settings who have the potential for exposure to patients presenting with an emerging respiratory threat including coronavirus.
2. To prevent the transmission from person to person of respiratory pathogens.
3. To prepare for emerging threat of Covid19.
4. To provide guidance for screening of suspected Covid-19 cases.
5. Facemask's will be worn by all employees

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15	F 880		

working in a facility where any clinical activity or patient care is being delivered, or while providing services in a patient's home.
6. Healthcare workers, when in close contact or providing continuous care for 15 minutes or more, will wear eye protection unless the patient or resident is wearing a cloth or surgical mask.
7. Upon identification of any resident with suspected or positive Covid19, a droplet precautions sign will be posted on the outside of the resident's room. The resident will be isolated in their room with the door closed. Staff will wear eye protection that covers both the front and sides of the face.
8. Appendix C: PPE Conservation - Reuse: all caregivers providing direct patient care will receive one surgical facemask per day/shift and a faceshield. Those not providing direct care, but who work in any facility where any clinical activity or patient care is being delivered, or interactions occur, will receive one surgical facemask per five days/shifts and a faceshield. All health care workers must wear eye protection when in close contact/providing continuous care for 15 minutes if the patient/resident is not wearing a cloth mask or surgical mask.

Facility policy titled Cohorting Plan for Skilled Nursing Facilities (SNFs), updated 6/4/20, indicated:
1. Facilities should plan to identify red, yellow and green zones where the residents can be cohorted based on their symptoms and exposure risks to Covid19. Facilities are also recommended to establish a transitional zone (gray zone) for asymptomatic patients who are being transferred from other healthcare facility. The residents will be placed in different zones

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16	F 880		

based on meeting certain criteria.
2. All nursing homes should consider establishing a transitional zone for new admissions, returning residents from the hospital or those who are traveling in and out of the nursing home. Transitional zones/units are established to quarantine those residents who are at somewhat higher risk of getting exposed to Covid19 but have no know exposure to Covid19.
3. Residents are kept in this zone for 14 days. If he/she remains asymptomatic (no new symptoms, no fever) at the end of the 14 days without the use of antipyretics (fever reducing medication), he/she will be moved to the green zone.
4. Light red zone criteria: all residents who are symptomatic and suspected to have Covid19 even if the test results are not back.
5. Dark red zone criteria: all residents that have tested positive for Covid19.
6. Yellow (quarantine zone) criteria: all asymptomatic residents who may have been exposed to Covid19.
7. Green zone (covid-free) criteria: all asymptomatic residents who are not considered to be exposed to Covid19.
8. Gray zone (transitional zone) criteria: all asymptomatic residents who are being admitted/readmitted to the nursing home from an outside facility and have no known exposure to Covid19.
a. Healthcare workers should wear PPE as follows: surgical mask, eye protection, and gloves as needed when taking care of these patients.
b. Residents are kept in this zone for 14 days. If he/she remains asymptomatic (no new symptoms, no fever) at the end of the 14 days without the use of antipyretics, he/she will be moved to the green zone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245558	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET WINDOM, MN 56101**

(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

Electronically delivered
July 16, 2020

Administrator
Good Samaritan Society - Windom
705 Sixth Street
Windom, MN 56101

Re: State Nursing Home Licensing Orders
Event ID: GBMQ11

Dear Administrator:

The above facility was surveyed on June 23, 2020 through June 24, 2020 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/23/20 and 6/24/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found not in compliance with the MN State Licensure. The following complaint was found to be found to substantiated:	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 #H5558023C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, monitor and implement interventions for 1 of 1 resident (R1), who experienced a fall with injury. R1 sustained actual harm, a subdural hematoma and pelvic fracture resulting in a discomfort and a decline in mobility. Findings include:	2 830	Corrected Date: July 31, 2020 It is the current policy and procedure of GSS-Windom to provide quality care to all clients. R1 went to the hospital on June 17, 2020 and returned to the facility on June 19, 2020. While R1 was hospitalized, a palliative medicine consult for clarification	7/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 2 R1's admission record indicated the resident was admitted to the facility on 2/8/19. R1's diagnoses record identified current diagnoses to include: Alzheimer's disease, osteoarthritis, hemiarthroplasty of the left hip, essential hypertension and diabetes mellitus type 2. Review of R1's quarterly Minimum Data Set (MDS) assessment dated 5/15/20, identified R1 as having a brief interview for mental status (BIMS) score of "7" (indicating R1 had moderately impaired cognition). The MDS indicated R1 was independent with bed mobility and transfers with set up assistance only. The MDS also indicated R1 was independent with ambulating in room with set up assistance and ambulated in the corridor with staff supervision, and a walker for ambulation. Further, the MDS indicated R1 was independent with toileting, and exhibited no impairment in range of motion (ROM) to the upper or lower extremities. During observation on 6/23/20, at 10:30 a.m. R1 was resting in bed. R1 was observed to be repositioned by staff while in bed. R1 offered no complaints during the care, but stated she wanted to go home. R1's left eyebrow was slightly swollen and bluish in color. Review of an incident report dated 6/17/20, at 5:00 a.m. indicated R1 experienced an unwitnessed fall in her room. The report indicated R1 alerted staff she had fallen by yelling out loudly. R1 was found laying on her right side on the floor. The report indicated R1 stated she was attempting to go to the bathroom when she fell. R1 was incontinent and obtained a laceration to the outer left eyebrow that was swollen and bleeding. The laceration was identified a s measuring 3.0 centimeters (cm). Steri-strips and	2 830	of goals of care and recommendations for symptom management/anticipated symptom management was completed. Upon return, hospice services were initiated, which currently includes a weekly RN visit. Additionally, the physician of record did a follow-up visit with R1 at the facility on July 8, 2020. Current treatment includes scheduled and PRN pain medicine. R1's care plan was updated on June 20, 2020. All residents with falls in the past 60 days are at potential risk for this deficient practice. These residents will be reviewed for initiation and completion of appropriate assessments to meet their needs and provide them quality care by July 31, 2020. Any care plans will be updated as appropriate. New falls will be reviewed M-F to ensure proper assessment and interventions are completed. New falls with injury occurring on the weekend/holiday will be reported to the Director of Nursing or designee for review. 2830 To prevent further potential deficient practice, all nursing staff will be re-educated by the Director of Nursing and the Clinical Learning, and Development Specialist by July 31, 2020 regarding the policy and procedures for monitoring neurological checks and assessments, as well as the change in condition UDA and pain UDA. Education will include the critical importance of completing comprehensive assessments, expected monitoring in accordance with INTERACT tools, and appropriate interventions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 an ice pack were applied to control the bleeding, R1 complained of pain when touched. R1 had previously been independent with ambulating and toileting. The report further indicated R1 had no other injuries or complaints when assessed. Neurological checks were initiated. Review of R1's medical record included neurological checks on 6/17/20, at 5:30 a.m., 5:37 a.m., 6:05 a.m. and 9:13 a.m. 5:36 a.m. vital signs (VS) and neurological assessment (neuro) = within normal limits (WNL). Pain = 0 (pain scale of 1-10 meaning 1 mild and 10 severe). Eyebrow laceration oozing blood. Ice Pack applied. 5:37 a.m. VS and NA = WNL. Pain = 1 6:05 a.m. VS and NA= WNL. Pain=0. Slight oozing of blood from eyebrow laceration. 9:13 a.m. VS and NA = right leg and left leg weak. Pain =1. No action was taken when R1 was identified with weakness in the lower extremities with pain. The progress note indicated R1 was having difficulty standing and required extensive assistance to the toilet. A mechanical lift was required. The note also indicated R1's left eyebrow laceration continued to bleed and R1 was refusing to eat. There were no further VS or neuro checks completed after 9:13 a.m. when R1 exhibited signs of a change in condition. The medical record indicated R1 was given scheduled Tylenol at 7:39 a.m. There was no offer of pain medication at any other time. R1's post fall progress notes were reviewed for 6/17/20: At 6:04 a.m. an entry indicated R1 was resting in	2 830	Additional education and monitoring will be provided for CM-1 regarding critical thinking skills needed for quality assessment by July 31, 2020 and on-going. The citation will be reviewed at the July 29, 2020 QAPI meeting with a Mini Model for Improvement initiated as appropriate. An audit of residents with falls and the completion of assessments and data collection tools based on policy and procedure will be conducted by the Director of Nursing Services or designee, weekly for 12 weeks. All audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4	2 830		

bed, denied complaints of pain and an ice pack was applied to the left side of the forehead. R1's laceration on the forehead was described in the notes as having 10 cm of blood from the area.
At 7:39 a.m. an entry indicated R1 required assistance of a pivot transfer to wheelchair when assisted to the bathroom. The note further indicated R1 had no complaints.
At 9:20 a.m. an entry indicated a fax was sent to the provider indicating R1 had a fall and obtained a 3.0 cm laceration on the left outer eyebrow. Steri-strips and an ice pack were applied with no other injuries noted. (There was no return fax from the provider verifying notification).
At 9:24 a.m. an entry indicated R1 was attempting to get out of bed but required extensive assistance of staff to the toilet. R1's laceration on the left eyebrow was described as bleeding, and the note indicated a new pressure dressing was applied to control the bleeding. R1 refused breakfast when offered. The note further indicated R1 had trouble standing during assistance to the toilet and a standing lift was needed.
At 10:36 a.m. an entry indicated R1 was scratching at the laceration on her left eyebrow and causing it to bleed more.
At 11:53 a.m. an entry indicated R1's eyebrow laceration continued to bleed and new steri-strips and pressure dressings were applied.
At 11:55 a.m. an entry note indicated there was increased bleeding from R1's laceration on the left eyebrow and another pressure dressing was applied due to saturation of blood. The note further indicated R1 had blood under her fingernails and may have been scratching at the laceration.
At 12:20 p.m. an entry indicated R1 refused to eat dinner when offered.
At 12:42 p.m. an entry indicated the laceration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5	2 830		

over R1's left eye continued to ooze blood and the eye was swollen shut. The facility's physician assistant (PA) was notified and indicated she would provide a house visit to assess the resident.
At 1:03 p.m. an entry indicated the facility PA assessed R1 and ordered a transfer to the emergency department (ED) by ambulance for further evaluation of the head wound and left hip pain.
At 2:24 p.m. an entry indicated a nurse from the ED informed the facility R1 was being transferred to the Mayo hospital in Mankato MN for further treatment, due R1 having a subdural hematoma and pelvic fracture.

A summary of the progress notes indicated R1 had a change in condition at 9:24 a.m. when R1 had difficulty standing and required extensive assistance of staff to the toilet, requiring a mechanical lift. R1 had previously been independent with mobility. R1's laceration on the left eyebrow continued to bleed requiring continued pressure and the resident was refusing to eat. The medical record did not include a thorough evaluation/assessment of R1's decline in condition or weakness, nor did it include a pain assessment to include thorough monitoring of R1's left hip pain or control.

Review of the PA visit progress note dated 6/17/20, at 1:00 p.m. indicated the PA was notified by facility staff R1 had fallen and had become more lethargic since the fall. The PA stated she was told by staff R1 was previously independent with mobility, but since the fall had been in bed and now required total assistance. The PA indicated she was informed R1 refused to eat or drink all day other than a sip of water taken with her medications at 9:00 a.m. on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 6/17/20. The PA stated facility staff had further informed her they'd been unable to control the bleeding from R1"s left eyebrow laceration after the fall, even when applying pressure. The PA also stated she was informed R1 had complained of nausea right after the fall, and stated the staff had reported they'd changed the pressure dressing to the resident's left eyebrow laceration 3-4 times throughout the day and could not obtain homeostasis. The PA indicated R1 had also reported left hip pain. Review of the 6/17/20 physical exam results by the PA, indicated R1 was identified to be lethargic and moaning in pain. R1 responded but did not open her eyes during the exam. The laceration on R1's left eyebrow was actively bleeding and swollen with an obvious hematoma formation. Finally the PA's note indicated R1 was to be transferred by ambulance to the ED for further evaluation. Review of an ED progress note dated 6/17/20, at 2:20 p.m. indicated R1 was examined after arrival to the ED. R1 continued to have bleeding from the facial laceration as well as moderate complaints of left hip pain. A computed tomography (CT) scan of the head was ordered with findings of an acute cerebral convexity subdural hematoma with periorbital soft tissue swelling. A CT scan of the pelvis was ordered with findings of an acute minimally displaced fracture of the left pubic body. The ED progress note indicated R1 would be transferred to the Mayo hospital in Mankato MN for further evaluation and treatment. Review of a Mayo hospital discharge summary note dated 6/19/20, indicated R1's fractured pelvis and subdural hematoma were evaluated and it had been determined R1 was a high risk surgical candidate and therefore surgery was not	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7	2 830		

recommended. R1's family chose comfort care measures only and R1 was discharged back to the nursing home facility with hospice care services

During an interview on 6/23/20 at 11:45 a.m., case manager (CM)-A stated she provided care for R1 after the fall. CM-A stated she felt R1 was stable until around 11:30 a.m., when R1's eyebrow laceration continued to bleed. CM-A further stated she felt R1's condition had not changed enough to warrant notification of the provider until that time. CM-A stated, "Although [R1's] laceration on the eyebrow continued to bleed, [R1's] neuro and VS were within normal limits even though a change in [R1's] mobility had been identified by a nursing assistant at 9:13 a.m.." CM-A confirmed R1 had been independent with mobility before the fall and at 9:13 a.m. on 6/17/20, R1 could not bear weight requiring a mechanical lift for transfers. CM-A also confirmed R1 had periods of left hip pain, but felt it was minimal. CM-A stated she'd only called the physician assistant (PA) because she thought R1's laceration needed stitches to stop further bleeding.

During interview on 6/23/20 at 11:30 a.m., nursing assistant (NA)-A and NA-B stated they had both provided care for R1 on 6/17/20, after the fall. NA-A and NA-B stated R1 started to complain of left hip pain around 8:30 a.m. when repositioned in her bed. NA-A and NA-B said R1 was weak and required total assistance with all activities of daily living (ADL's) that included mobility. NA-A and NA-B confirmed R1 had been independent with mobility prior to the fall. NA-A and NA-B further indicated R1's laceration on the left eyebrow continued to swell and bleed through several pressure dressings throughout the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8	2 830		

morning. NA-A and NA-B further added R1 had been sleepier, refused to eat and stayed in bed all morning. NA-A and NA-B both stated they reported R1's changes in condition to CM-A when identified.

According to interview with registered nurse (RN)-A on 6/23/20 at 2:45 p.m., RN-A confirmed she'd provided care for R1 at the time of the fall. RN-A stated she assessed R1 and did not identify any injuries other than a 3.0 cm laceration above the left eye, that was noted to be bleeding slightly. RN-A stated R1 denied complaints of pain when RN-A evaluated R1's extremities, adding that R1 was alert and she didn't note any change in cognition. RN-A further indicated a mechanical lift was used to transfer R1 back into bed per protocol. RN-A stated she was unsure whether R1 could bear any weight at that time because they did not attempt to have R1 bear any weight.

When interviewed on 6/23/20 at 3:00 p.m., the facility's physician assistant (PA) confirmed the above documented dictated notes from the visit she made for R1 on 6/17/20. The PA stated when she examined R1 there was blood all over the resident's face, neck and upper body from the laceration on the left eyebrow, and the left eye was swollen shut. The PA stated there was a lot of bleeding from the laceration making it difficult to see the depth of the wound. The PA further indicated R1 was moaning in pain during attempts to sit her up in bed. The PA stated she assessed R1's extremities and the resident complained of left hip pain with range of motion (ROM). The PA further reported staff had informed her R1 had been more lethargic and weak, and the dressing on the eyebrow had required several dressing changes over the prior hour, due to increased bleeding and saturation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9	2 830		

the dressings. The PA stated she should have been notified sooner when the resident's condition was noted to have changed. Changes that included not bearing weight and requiring a mechanical lift for transfers, pain in the left hip area, and the uncontrolled bleeding from the laceration on the left eyebrow were significant, and the PA stated earlier treatment could have prevented or decreased discomfort for R1.

The director of nursing (DON) and administrator were interviewed on 6/24/20 at 1:00 p.m., and reviewed the record with the surveyor. They confirmed R1's condition had declined after the fall. The DON stated staff had not implemented the facility's policy/guidelines for monitoring neurological checks/assessments, nor had the staff completed the facility's change in condition checklist, or provide interventions to provide comfort for R1. The DON and administrator verified the medical provider should have been contacted to provide direction related to changes observed for the resident.

The facility's procedure Neurological Evaluation revised 1/20, indicated staff were to complete a neurological evaluation when a resident had an unwitnessed fall, or following an event that results in a known or suspected head injury. The procedure included: Initiate and document a baseline neurological evaluation after the incident, notify the provider of the event and findings of the evaluation, obtain orders for subsequent neurological evaluations or other medical care, after the completion of the initial neurological evaluation with vital signs, continue with evaluations every 30 minutes for 4 times, then every 8 hours for 3 days or as directed by the provider. The policy further included: Evaluate and compare subsequent neurological

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 evaluations to the initial baseline and previous evaluations and notify the provider of any neurological findings, which are a change from the baseline or previous evaluations. The facility's procedure for Change in Condition Evaluation revised 5/16/20, directed staff to complete a change in condition checklist to improve communication between nurses and the provider when nursing was monitoring a change in condition, and to enhance the nursing evaluation and documentation of a resident who has a change in condition. The procedure indicated the evaluation would provide a standard format to collect pertinent clinical data prior to contacting the provider when there was a change in condition. SUGGEST METHOD FOR CORRECTION: The director of nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving appropriate assessment and necessary interventions. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents;	21390		7/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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
21390	Continued From page 11 B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing preventive measures to prevent the spread of COVID-19. This had the potential to affect all 61 residents who resided at the facility. Finding include: During an observation on 6/24/20, at 11:00 a.m. licensed practical nurse (LPN)-A was in the nurses' station without a facemask, preparing to	21390	21390 Corrected Date: July 31, 2020 It is the current policy and procedure of GSS-Windom to follow appropriate infection control practices in accordance with policy and procedure, as well as state and federal regulations. All residents were re-educated on wearing face masks the week of June 29, 2020. At this time also, bags containing face masks were provided to each client to facilitate the use of them.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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
21390	Continued From page 12 give a resident medication. The resident was approximately one to two feet away from LPN-A and was also unmasked. LPN-A stated when he is at the nurses' station he is not required to wear a facemask, and further stated he got too hot wearing the mask. During an observation on 6/24/20, at 11:15 a.m. activity assistant (AA)-A was in the lounge sitting within a foot of a resident reading a book. AA-A was not wearing eye protection. AA-A stated she was not required to wear eye protection, except when feeding a resident. During an interview on 6/24/20, at 11:30 a.m. the activity department director (AD)-B confirmed activity staff were only required to wear eye protection when feeding a resident. During an observation and interview on 6/24/20, at 11:40 a.m. registered nurses (RN)-B and (RN)-C were in the nurses' station, not wearing facemasks or eye protection. The nurses' station was open to the unit, having only two walls and one counter-height peninsula. During the observation, residents self-propelled or walked within six feet of these staff. RN-B and RN-C stated they were not required to wear a facemask or eye protection at the nurses' station. During an observation and interview on 6/24/20, at 11:45 a.m. R1 was seated in the north dining room with other residents, eating lunch. R1 was on day five of a 14 day quarantine after returning from the hospital on 6/19/20. Registered nurse (RN)-A stated that R1 was considered to be in the "gray zone" per the facility cohort plan. RN-A stated R1 was not confined to her room for the 14 day quarantine period and while staff were required to wear a facemask, eye protection, and gloves when caring for R1, a gown was not	21390	All resident care plans were updated, as appropriate, for each client the week of June 29, 2020. All staff will continue to encourage residents to wear their masks. Management will provide ongoing education to the residents, as needed, to encourage the wearing of masks by residents. Throughout the pandemic, new admissions will be educated, assessed, and care planned for their individual needs regarding face mask wearing. To prevent further potential deficient practice, immediate staff education was provided concerning 3 topics: encouraging residents to wear face masks, the appropriate wearing of PPE by all staff in resident areas, and clarification of Gray Zone PPE requirements. All staff will be further educated by the Director of Nursing and Infection Preventionist by July 31, 2020, regarding the appropriate usage and wearing of PPE for both residents and staff, based on current policy and recommendations. Throughout the pandemic, all new staff will be trained on these same topics. The gray zone PPE and signage requirements were updated to include gown usage. Surveyors re-educated management on the MN DOH requirements and provided information as requested by management. As the pandemic situation evolves, management will continue to participate in available education opportunities. The citation will be reviewed at the July 29, 2020 QAPI meeting with a Mini Model for Improvement initiated as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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
21390	Continued From page 13 required. During an observation on 6/24/20, at 12:05 p.m., residents were observed self-propelling in hallways without masks. During an interview on 6/24/20, at 12:10 p.m. in her room, R4 stated "we're not required to wear a mask here unless we leave for an appointment." During an interview and observation on 6/24/20, at 12:20 p.m. the director of nursing (DON) stated residents wear a mask when they leave their room "if they want to." The DON further stated residents are asked at the time of admission if they want to wear a mask. The DON was observed wearing her personal eye glasses with detachable eye shields on each side, for eye protection. During an observation and interview on 6/24/20, at 12:45 p.m. RN-A was sitting at the nurses' station with her mask off, interacting with a staff person who was one to two feet away. RN-A stated staff were not required to wear facemasks while at the nurses' station. On 6/24/20 at 12:50 p.m., R1 was observed resting in her room on the north end of the facility. There were no signs outside her door indicating she was in quarantine and no cart outside her room for personal protective equipment (PPE). During an observation on 6/24/20, at 12:55 p.m. nursing assistant (NA)-A was feeding two residents at a dining table with her facemask below her nose. NA-A stated it was hard to breathe with her mask on, so she put it below her nose at times. During an interview on 6/24/29, at 1:00 p.m. the	21390	An audit of residents and staff members wearing PPE as appropriate will be conducted by the Quality Coordinator or designee, 5 times per week, on various shifts for 12 weeks. A combination of observation and knowledge verification will be used. All new staff will have a competency completed to verify PPE knowledge and skill. All audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure solutions are sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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
21390	Continued From page 14 administrator stated R1 was not quarantined, and stated the facility was using guidance from their corporation to determine which residents required quarantine. The administrator said R1 did not meet quarantine criteria therefore staff were not required to wear gown and gloves when entering R1's room to provide care. During an interview on 6/24/20, at 1:15 p.m. DON stated she thought residents could be asked if they wanted to wear a mask. The DON stated residents are offered masks weekly, but have the option to refuse. Further, the DON stated it was acceptable practice for staff to remove their eye protection and/or mask when at the nurses' station when not providing direct care to a resident. The DON stated staff were required to wear a facemask and eye protection when feeding a resident. Facility policy titled Infection Prevention, revised date 6/16/20, indicated: 1. Purpose was to provide guidance to healthcare personnel working in healthcare settings who have the potential for exposure to patients presenting with an emerging respiratory threat including coronavirus. 2. To prevent the transmission from person to person of respiratory pathogens. 3. To prepare for emerging threat of Covid19. 4. To provide guidance for screening of suspected Covid-19 cases. 5. Facemask's will be worn by all employees working in a facility where any clinical activity or patient care is being delivered, or while providing services in a patient's home. 6. Healthcare workers, when in close contact or providing continuous care for 15 minutes or more, will wear eye protection unless the patient or resident is wearing a cloth or surgical mask.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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
21390	Continued From page 15 7. Upon identification of any resident with suspected or positive Covid19, a droplet precautions sign will be posted on the outside of the resident's room. The resident will be isolated in their room with the door closed. Staff will wear eye protection that covers both the front and sides of the face. 8. Appendix C: PPE Conservation - Reuse: all caregivers providing direct patient care will receive one surgical facemask per day/shift and a faceshield. Those not providing direct care, but who work in any facility where any clinical activity or patient care is being delivered, or interactions occur, will receive one surgical facemask per five days/shifts and a faceshield. All health care workers must wear eye protection when in close contact/providing continuous care for 15 minutes if the patient/resident is not wearing a cloth mask or surgical mask. Facility policy titled Cohorting Plan for Skilled Nursing Facilities (SNFs), updated 6/4/20, indicated: 1. Facilities should plan to identify red, yellow and green zones where the residents can be cohorted based on their symptoms and exposure risks to Covid19. Facilities are also recommended to establish a transitional zone (gray zone) for asymptomatic patients who are being transferred from other healthcare facility. The residents will be placed in different zones based on meeting certain criteria. 2. All nursing homes should consider establishing a transitional zone for new admissions, returning residents from the hospital or those who are traveling in and out of the nursing home. Transitional zones/units are established to quarantine those residents who are at somewhat higher risk of getting exposed to	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	705 SIXTH STREET WINDOM, MN 56101

(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
21390	Continued From page 16 Covid19 but have no know exposure to Covid19. 3. Residents are kept in this zone for 14 days. If he/she remains asymptomatic (no new symptoms, no fever) at the end of the 14 days without the use of antipyretics (fever reducing medication), he/she will be moved to the green zone. 4. Light red zone criteria: all residents who are symptomatic and suspected to have Covid19 even if the test results are not back. 5. Dark red zone criteria: all residents that have tested positive for Covid19. 6. Yellow (quarantine zone) criteria: all asymptomatic residents who may have been exposed to Covid19. 7. Green zone (covid-free) criteria: all asymptomatic residents who are not considered to be exposed to Covid19. 8. Gray zone (transitional zone) criteria: all asymptomatic residents who are being admitted/readmitted to the nursing home from an outside facility and have no known exposure to Covid19. a. Healthcare workers should wear PPE as follows: surgical mask, eye protection, and gloves as needed when taking care of these patients. b. Residents are kept in this zone for 14 days. If he/she remains asymptomatic (no new symptoms, no fever) at the end of the 14 days without the use of antipyretics, he/she will be moved to the green zone. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could audit resident cares for appropriate hand hygiene, and educate all direct caregivers on proper technique. The DON or designee could audit the appropriate use of facemask and eye protection, and educate all staff on the requirements of use.The DON or designee could report findings of	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00085	A. BUILDING: _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WINDOM	**705 SIXTH STREET WINDOM, MN 56101**

(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
21390	Continued From page 17 the audits to the quality assurance committe for follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		