STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245595	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Westbrook	149 First Street, Box 218 Westbrook, MN 56183

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and document review, the facility failed to ensure the IP brought data forth measurable data to 1 of 1 Quality Assurance Performance Improvement (QAPI) committee. This had the potential to affect all 32 residents. Findings include: Review of the QAPI meeting minutes from the past four quarterly meeting minutes identified: 1). November 14,2025, (Quarter 4), Infection Control (IC) documentation included data of Monthly infection summary which included numbers and types of infections. The minutes identified numbers for the current month compared to the previous month with a comparison percentage, but no breakdown, analysis or discussion for an ongoing plan identified 2). September 16, 25. (Quarter 3), IC minutes documentation included a general goal of less than 7% compared to the current performance of 10.19%. There was no identified data included to identify what was included in the percentages. Analysis identified the plan to continue education regarding personal hygiene provided to residents, but there was no surveillance data or investigation into patterns or possible analysis of the data. 3). June 27, 2025, (Quarter 2), IC minutes documented number of resident infections with type listed, along with the percentage compared to the previous month. The goal identified a percentage, but there was no documentation to indicate analysis of root cause of infections, discussion as to potential interventions other than general comments to educate staff as needed. The report listed audits had been completed for 48-hour progress notes, but there was no identification of findings for the audits, or discussion regarding potential interventions with a plan identified. 4). January 26, 2026, (Quarter 1), IC minutes included goals for types of infections with comparison to previous month, but there was no tracking of potential source, or patterns identified. The minutes failed to include any discussion of data, with analysis of potential source, and determination of appropriate interventions to be initiated. Interview on 3/18/26 at 8:41 a.m. with the Infection Preventionist reported she had not been providing on-time infection control surveillance for residents and staff as her practice was to collect infection information place it in a folder on her desk and compile a report the week following the end of the month. She confirmed this practice did not allow her to analysis and develop a process for discussion of the findings at the QAPI meetings. She agreed that review of the Quarterly IC minutes did not include discussion of findings or development with documentation of a plan to go forward with the findings identified in her report. Interview on 3/18/26 at 11:00 a.m. with the administrator identified her expectation for the IP to provide evidence of surveillance, analysis and suggestions for discussion of a plan to monitor and prevent potential outbreak of infections in the facility. Review of the February 2024 Quality Assurance and Performance Improvement (QAPI) policy identified the facility was to have a QAPI plan to address resident's Quality of Life, and resident choices. The plan was to be developed according to details included in the Facility Assessment. The policy identified the QAPI program was to identify areas of high risk, high volume, and/or problem areas for improvement by identifying and correcting the areas of deficiency.The components to be included:1.) Tracking and measure of performance2.) Establish goals with thresholds for performance improvement.3.) Identify and prioritize areas of quality deficiencies.4.) Analyze causes of deficiencies.5.) Develop and implement corrective action plans.6.) Monitor and evaluate the action plan with revisions, as necessary.

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.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and document review the facility failed to provide surveillance and implement Transmission Based Precautions (TBP) for 7 of 7 residents (R6, R12, R16, R25, R29, R30 and R31) who were experiencing cold/respiratory signs and symptoms. The facility also failed to ensure nebulizer equipment was appropriately rinsed and dried after each use for 3 of 3 residents (R25, R29, and R30) and ensure appropriate cleaning and disinfection occurred for 1 of 1 multi-resident use whirlpool tub. This deficient practice had the ability to affect all 32 residents in the facility. Findings include: Whirlpool cleaning and disinfection: Observation on 3/18/26 at 10:10 a.m. with nursing assistant (NA)-A identified she prepared to disinfect the whirlpool tub by applying gloves, returned the bath chair into the tub, closed the door of the tub, and explained she liked to turn on the air jets for about 30 seconds at the beginning of the process to clear any debris that may have been in the bath. NA-A closed the drain, removed the belt attached to the chair and placed it into the well of the tub and the cushion remained attached on the seat of the bath chair. NA-A turned on the switch to fill the tub with the disinfectant (CID AL II) to the first level about 2 inches. The belt was immersed in the disinfectant, but the bath chair with a cutout in the seat, remained above the level of the disinfectant solution. She then took a long handled brush and using the disinfectant solution in the tub well brushed over the surfaces of the tub, back rest and top of chair cushion, but Failed to clean the bottom of the chair cushion. After brushing the tub surfaces , she picked up the belt and brushed over both sides of the belt, before placing it back into the solution in the bottom of the tub. She had given four baths this morning and this was her last one. At 10:16 a.m., NA-A reported she needed to wait 10 minutes to allow the disinfectant to remain on the tub surface to allow for disinfection. She set her watch alarm for 10 minutes, and began cleaning up the room, by taking out used linens, trash and supplies. She did not re-wet the surface of the tub which continued to dray as she went about her tasks. The directions posted on the back of the control area of the tub listed step by step directions, which included -lift the seat bottom off chair. Use the cleaning solution to scrub the tub, chair and underneath seat bottom. NA-A returned at 10:26 a.m., and stated the 10 minutes had elapsed, and she could now drain and rinse the tub which was the final step. NA-A was asked about cleaning of the tub chair cushion and replied she had scrubbed the top of the cushion, but she was not aware the cushion was removable and agreed she had not cleaned the bottom of the seat. She stated she had never removed the cushion from the frame to clean the underside. She removed the cushion which was clipped onto the frame of the chair and upon turning it over dried white residue was noted spotting the underside of the cushion. In addition a brown substance was noted along the edge of the opening in the seat cushion, which NA-A remarked it was probably feces as the resident had a bowel movement during her bath. NA-A reported she performed the cleaning according to the printed instructions between each bath, but since this was the last bath of the day she was following the disinfection procedure. She identified she had not removed the seat cushion between baths, and was not aware that it could be removed for cleaning. Observation and interview on 3/18/26 at 10:30 a.m. with the administrator who came to the tub room and observed the bath chair cushion, voiced agreement the chair cushion had not been cleaned appropriately, and she expected all components of the tub and chair to be cleaned and disinfected after each bath. She further stated it was likely other staff were also not aware the seat cushion was removable for cleaning and as a result would be implementing retraining. Review of the current, undated Advantage Seated Bathing System Cleaning and Disinfecting Process (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for Air Spa Series, Manufacturer's Guideline identified Staff were to: Turn off the blower and lift the seat bottom off the chair. Use the cleaning solution/disinfectant to scrub the tub, chair and underneath the seat bottom. Leave wet for 10 minutes, then open the tub drain and turn the blower on, turn the selector knob to Rinse and the control knob to on, and when clear water comes out of all outlets, turn the control knob off. Leave the blower on for 60 seconds to force the remaining water out of the airlines. Turn the blower off and use the shower wand to rinse the tub and chair. Review of the 12/2/24, Infection Prevention and Control Program Policy identified the program to prevent, identify, investigate, and report in the attempt to control infections and communicable diseases for residents, staff, and visitors in a facility. The program was to follow the nationally accepted standards, and guidelines for infection control. The program was to include an acceptable system to monitor and document infection control and prevention. The program was to be reviewed annually by the IP or designee, to ensure compliance. The IP utilizes surveillance data to identify outcomes, trends and patterns with results communicated to the QAPI committee. TBP Observation on 3/17/26 at 9:00a.m. during the initial tour, identified no residents were identified as being on Transmission-based precautions (TBP). Interview on 3/17/26 at 9:00a.m. with the director of nursing (DON during the entrance conference identified there were some resident with cold symptoms, but none had been placed on TBP. Observation and interview on 3/17/26 at 10:00a.m., of R6 in his room identified he/she showed signs and symptoms (S/S) of congestion and had a hoarse voice. Staff were entering and exiting the room with no Personal Protection Equipment (PPE) in use. Observation of R12 on 3/17/26 at 10:15 a.m. identified S/S including cough, congestion, and fever. The electronic medical record (MAR) identified the S/S had initiated on 3/8/26. Observation of R16 on 3/17/26 at 11:00 a.m. identified S/S including congestion and a hoarse voice. Observation of R25 on 3/17/26 at 11:15 a.m. identified S;/S including cough, congestion and shortness of breath (S.O.B.). The MAR identified the S/S had developed on 3/12/26. No precautions were in place, nor PPE in use by staff entering the room or caring for the resident. Observation/interview of R29 on 3/17/26 at 11:20 a.m. identified she had no S/.S, but she reported she had self isolated to avoid residents who were coughing and sneezing in the common areas of the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation/interview of R30 on 3/17/026 at 11:30 a.m., identified he had S/S including fever, cough and S.O.B. R30's medical record progress notes identified S/S had been noted on 3/13/26. Observation and interview on 3/17/26 at 11:45 a.m. of R31 identified she had developed a cough, complained of chest congestion and S.O.B. which the MAR progress note identified had begun on 3/8/26. There was no signage on any of the above resident's doors that identified the need to use TBP to prevent the potential spread of possible infectious disease. R31 Interview on 3/17/26 at 9:00 a.m., with the director of nursing (DON) identified the facility had no residents on transmission-based precautions for confirmed or suspected respiratory infections. R31's 2/9/26, comprehensive Minimum Data Set (MDS) assessment identified her cognition was moderately impaired, she was independent with transfers and toileting and required set up and clean up assistance with dressing. R31 required moderate assistance from staff with bathing. Observation and interview on 3/17/26 at 10:14 a.m., of R31 identified she had not been feeling well for a while, she was observed to be holding a Kleenex in her hand and coughing during the interview. She did not have any signage hanging on her room door to alert others that she had a potential infectious disease requiring transmission-based precautions. There was no personal protective equipment (PPE) available for staff to put on prior to entering her room. R31's 3/11/26, nursing progress note identified a fax was sent to the primary physician to notify him R31 has a very harsh cough. As needed, Mucinex and cough syrup was being administered. The physician responded with an order to start Tessalon capsules (an alternative to cough medicine). R31's nursing progress notes made no mention that she had been placed on isolation, advised to wear a mask when out of her room, that she had been tested for covid or influenza, or that monitoring had been set up. Review of R31's current medication orders identified she was to be administered Mucinex oral tablet extended release 800 milligrams (MG) every 12 hours as needed for cough and dextromethorphan-guaifenesin (cough syrup) 20 milliliters (ML) every 4 hours as needed for cough. In addition, R31's physician orders included testing at the facility for covid and influenza A & B as needed for s/s of respiratory infection. Interview and document review on 3/19/26 at 8:34 a.m., with the activity director identified R31 attended a happy hour (group activity held in the dining room with food and drinks) activity on 3/13/26 and the St Patrick's Day party on 3/17/26, with other residents and staff. Interview on 3/17/26, at 10:30 a.m., with the infection preventionist (IP) identified she would have expected nursing staff to place residents on precautions upon observation of respiratory infection signs and symptoms. Once the resident is placed on precautions, nursing should complete testing for Covid and Influenza. If the resident tested negative, they could leave their room if they are wearing a mask. The IP identified the facility has the supplies to test for Covid and influenza A & B at the facility, however, they do not have the ability to test for RSV (a highly contagious respiratory syncytial virus that can be dangerous for older adults) or any other respiratory infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R31's 3/17/26 nursing progress note identified she was tested for covid and influenza due to cough and chest congestion. R31 was placed on precautions until symptoms resolve, or 2 negative covid test results are obtained. R6's 3/2/26, accepted comprehensive Minimum Data Set (MDS) identified R6's cognition was severely impaired. R6 was independent with eating and required partial assistance from staff with bed mobility and transfers and required substantial assistance with personal hygiene and toileting. R6 had diagnoses of coronary artery disease, high cholesterol, osteoporosis, depression, dementia and Parkinson's disease. Observation on 3/17/26 at 11:05 a.m., identified R6 had a personal protective equipment (PPE) (gowns, gloves, mask) cart placed outside of his room with a transmission-based precautions (TBP) sign on his door, indicating anyone entering R6's room must wear surgical mask, perform hand hygiene, use eye protection and wear a gown. R6's medical record reviewed on 3/17/26, made no mention that he had been placed on precautions or why R6 had been tested for COVID and influenza A & B. There was also no indication in the medical record that a respiratory assessment had been completed, or monitoring had been set up at that time. R16's 2/23/26, accepted quarterly MDS identified R16's cognition was severely impaired. R16 was independent with eating, and needed substantial assistance from staff for personal hygiene, toileting, bed mobility, and transfers, and was dependent on staff for dressing. R16's had diagnoses of heart disease, arthritis, anxiety, depression, dementia, and Parkinson's disease. Observation and subsequent interview on 3/17/26 at 10:05 a.m., with licensed practical nurse (LPN)-A, identified she entered R16's room without donning PPE first and closed the door. LPN-A then came out of R16's room and reported she had just tested R16 for COVID and influenza. LPN-A gave no indication why she had not donned PPE prior to entering R16's room to test for COVID and influenza to rule out a potential infectious disease. Observation on 3/17/26 at 10:34 a.m., of R16 identified he was seated in the dining room at his table eating his breakfast. R16 was seated alone at the table with no mask visible. Observation on 3/17/26 at 11:03 a.m., of LPN-A identified she was directing nurse aide staff to place a PPE cart outside of R16's room. Staff acknowledged LPN-A's direction and reported they would need to go get R16 from the dining room. Interview on 3/17/26 at 11:06 a.m., with LPN-B identified R6 had a cough, and he was congested and R16 had respiratory symptoms as well. Their symptoms begin on 3/17/26, and both R6 and R16 were tested today. The results of both residents were negative, and they would be tested again in 2 days. Both were placed on TBP due to their respiratory symptoms. Observation on 3/17/26 at 11:12 a.m. through 11:17 a.m., of R16 identified he remained seated at the dining room table and was done eating breakfast and was now waiting for the noon meal. R16 remained unmasked. Staff are bringing other residents into the dining room for lunch. R16's table mate arrived and was seated at table next to R16 after R16 had been tested for respiratory system. Staff approached R16 unmasked and spoke to him. Staff then proceeded to wheel R16 out of the dining room without a mask and pushed him back to his room. R16 had a PPE cart outside of his room with a TBP sign on his door that indicated anyone entering the room must wear surgical mask, perform hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hygiene, use eye protection and gown. Interview on 3/17/26 at 11:19 a.m., with LPN-A reported she was unsure why staff took R16 out of his room for breakfast as she had tested R16 that morning for potential infectious respiratory disease after staff had reported to her that R16 had respiratory symptoms. She reported R16 should have stayed in his room. LPN-a did not indicate she had instructed staff to leave R16 in his room or if he was taken out of his room, staff were to ensure he wore a mask or seat him alone in the dining room to not expose residents near him. R16's medical record was reviewed on 3/17/26, and there was no mention he had been placed on TBP or why R16 had been tested for COVID and influenza A & B. There was also no mention R16 should wear a mask when out of his room, that a respiratory assessment had been completed, or monitoring had been set up. Further interview on 3/18/26 at 5:00 p.m., with LPN-A identified R6 had been at the desk after breakfast on 3/17/26 and was coughing. She had taken him back to his room and tested him for COVID and influenza. Staff had reported to her also that R16 sounded congested and that was why she had tested him. She revealed she did not complete a respiratory assessment on R6 or R16 and that was the reason there were no assessments in R6 or R16's medical record on 3/17/26. She did identify however, that she had some vitals documented on a piece of paper that she had not had time to enter the information into R6's or R16's charts yet, but she would be doing that today. She was unaware of any process for setting up specific monitoring for residents who displayed signs or symptoms of respiratory infection. Review of the 11/18/25, Infection Prevention and Control Program policy identified Transmission Based Precautions-specific measures would be used to protect residents, employees, visitors and other individuals from the spread of infection when the route of transmission is not interrupted by standard precautions alone. The type of precautions (i.e., airborne, contact, droplet) used depends on the potential for exposure, route of transmission, and infectious organism/pathogen or clinical syndrome if an organism is not yet identified. In addition, infection prevention and control education for residents/patients/clients, employees, visitors, and other individuals as appropriate for the healthcare setting. Nebulizer cleaning R29's 3/2/26, accepted quarterly MDS identified R29's cognition was intact. R29 was independent with eating and required substantial assistance from staff for personal hygiene, dressing, toileting, and transfers. R29 had diagnoses of heart failure, high blood pressure, depression, asthma, and chronic obstructive pulmonary disease. R29's Medication Administration record identified an order for DuoNeb Solution 0.5-2.5 milligrams/3 milliliter (mg/ml) inhaled medication, 1 inhalation, via a nebulizer machine one time a day in the morning. R30's 3/9/26, accepted comprehensive MDS identified R30's cognition was intact. R30 was independent with eating and required substantial assistance from staff for personal hygiene, dressing, toileting, and transfers. R30 had diagnoses of kidney insufficiency, Parkinson's disease, depression, and malnutrition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R30's current, March 2026, Medication Administration record identified a physician's order for Ipratropium-Albuterol inhalation solution, 0.5-2.5 mg/3ml 1 inhalation, four times a day. Observation on 3/17/26 at 9:24 a.m., of R29's and R30's shared room identified R29's nebulizer tee piece a handheld piece was still attached to the nebulizer machine sitting on bedside table next to her chair and had not been disconnected, rinsed, and left to air dry between use to remove residual medication. R30 had a nebulizer mask that was still attached to his nebulizer machine sitting on bedside table next to his chair that also had not been disconnected, rinsed, and left to air dry between use to remove residual medication. Observation and interview on 3/19/26 at 11:00 a.m., of R29's and R30's shared room identified R29's and R30's nebulizer mask were still attached to their nebulizer machines which were located on their bedside tables. R29 reported staff set up the machine for his/her use, and they would usually take their mask to the bathroom and rinse It out and bring it back sometime during the day, however, no staff had been into the room to do that yet. Later observation on 3/19/26 at 12:52 p.m., both R29 and R30 nebulizer mask were still attached to their nebulizer machines and remained on their bedside tables. Interview on 3/19/26 at 12:56 p.m., with director of nursing identified nebulizer attachments like a mask and handheld tee type was to be taken apart and rinsed after each use and left to air dry on a towel until the next use. R25's 2/2/26, accepted quarterly MDS identified R25's cognition was intact. She was independent with eating, needed partial assistance from staff for bed mobility, toileting and transfers, and needed substantial staff assistance for personal hygiene. R25 had diagnoses of high blood pressure, arthritis, anxiety, and chronic obstructive pulmonary disease. R25's current, March 2026, Medication Administration record identified a physician's order for Arformoterol Tartrate (a long-acting bronchodilator used to treat chronic bronchitis and emphysema) inhalation nebulization solution, 1 inhalation twice a day, morning and evening. Observation on 3/19/26 at 1:01 p.m., of R25's nebulizer machine which had a handheld tee piece device that was still attached to the machine located on the bedside table in her room that had not been disconnected, rinsed, and left to air dry between use to remove residual medication. Review of the 12/10/25, Nebulizer policy identified when a treatment was finished to clean the nebulizer after each use. Staff were to disconnect the tubing separate the nebulizer parts and wash with warm soapy water and rinse thoroughly, then place on paper towel to air dry until the next use.