Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 15, 2025

Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue
Pine River, MN 56474

RE: CCN: 245476
Cycle Start Date: February 5, 2025

Dear Administrator:

On March 7, 2025, we notified you a remedy was imposed. On March 25, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 11, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 5, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of March 7, 2025, 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 fromMay 5, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 11, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 15, 2025

Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue
Pine River, MN 56474

Re: Reinspection Results
Event ID: 1VT212

Dear Administrator:

On March 25, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 5, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 18, 2025

Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue
Pine River, MN 56474

RE: CCN: 245476
Cycle Start Date: February 5, 2024

Dear Administrator:

On February 5, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 5, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 5, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE PINE RIVER, MN 56474

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/2/25 through 2/5/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/2/25 through 2/5/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		3/12/25

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

Electronically Signed | 02/26/2025

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

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F 732	Continued From page 1 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 732	Preparation and execution of this	

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F 732	Continued From page 2 review, the facility failed to ensure the required nurse staffing information was consistently posted on a daily basis and failed to identify when the posting changed due to call ins. This had potential to affect all 26 residents along with staff and visitors who could wish to review this information. Findings include: During observation on 2/2/25 at 12:20 p.m., the staff in a clear hard plastic sleeve on the nurses' desk upon entrance to the facility. The staff posting form identified the facility name, date, census, shift and total hours for licensed practical nurse (LPN). nursing assistant (NA), registered nurse (RN) case manager, and RN. The posting for 2/2/25, identified a census of 26 (that was corrected from 27). The 6:00 am to 6:00 pm shift identified one NA but did not identify the total hours (hr) worked, one RN case manager for 11.5 hrs which is less than the 12-hour shift identified on the posting. The 6:00 a.m. to 2:30 p.m. shift identified one LPN for 8 hrs, one NA but did not identify the total hours worked. The 2:15 p.m. to 10 45 p.m. shift identified two NA's for a total of 4.25 hours which was not reflected of the shift, two RN's with no total hours identified. The 6:00 p.m. to 6:00 a.m. shift identified one NA for 11.5 hrs and one RN for 11.5 hours both of which were not the full 12 hours identified for the shift. Further, the posting failed to identify the staff hours worked due to call-ins, vacations and/or staff shortages. The working schedule for 2/2/25, identified from 6:00 a.m. to 2:30 p.m. there was one LPN and one NA, from 6:00 a.m. to 6:00 p.m. there was one RN and one NA, from 2:15 p.m. to 10:45 p.m. there was one RN, one LPN, and one NA, from 6:00 p.m. to 6:00 a.m. there	F 732	response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F732 – Posted Nurse Staffing The posted staffing schedule has been updated with accurate information, including right number of RNs, LPN, and CNAs that need to be on the schedule. It has also been updated to include the census and any call-ins or picked-up shifts per posting regulations. All residents in the facility have the potential to be affected by this deficient practice. As a result, facility administrator, director of nursing, and staffing coordinator and all nurses were immediately trained and given access to the BIPA report to print updated staffing levels per posting nursing staffing regulations and updating it with any changes. They will update changes immediately as they happen to reflect the correct hours worked.	

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F 732	Continued From page 3 was one RN and one NA. During observation on 2/3/25 at 4:11 p.m., the staff posting for 2/3/25, identified the facility name, date, census, shift and total hours for director of nursing (DON), health information management technician (HIM), LPN. NA, RN case manager, and supervisor ancillary services. The posting identified a census of 25 (corrected from 26.) The 6:00 am to 2:30 p.m. shift identified one LPN for a for 8 hrs, one NA without identifying the total hours worked. The 2:15 p.m. to 10:45 p.m. identified two NA's with a total of 4.25 hrs and two RN's without identifying the total hours worked. The 6:00p.m. to 6:00a.m. identified one NA for 11.5 hrs and one RN for 11.5 hours, the total hours worked did not match the shift. Further, the posting failed to identify the staff hours worked due to call-ins, vacations and/or staff shortages. The working schedule for 2/3/25, identified from 6:00 a.m. to 2:30 p.m. there was one LPN, one RN and two NAs, from 2:15 p.m. to 10:45 p.m. there were two LPNs and two NAs, from 10:30 p.m. to 7:00 a.m. there was one LPN and one NA. During observation on 2/4/25 at 11:13 a.m., the staff posting for 2/4/25, identified the facility name, date, census, shift and total hours for DON, HIM, LPN. NA, RN case manager, and supervisor ancillary services. The posting identified a census of 25 (corrected from 27). The 6:00 am to 2:30 p.m. shift identified one LPN for a for 8 hrs, two NA for a total of 16 hrs and one RN without identifying the total hours worked. The 8:00 a.m. to 4:30 p.m. shift identified the DON worked for 8hrs along with) RN case managers for a total of 8 hrs. The 2:15 p.m. to 10:45 p.m. shift Identified one LPN for 8 hrs with a	F 732	To ensure systemic changes are sustained, the “Nursing Staff Daily Posting Requirements” policy and procedures will be reviewed with all nursing staff at the March 12th nursing staff meeting. For 7-day posting, all nursing staff on all shifts received direct education from staffing coordinator on updating and printing the BIPA report to meet the posting nursing staffing requirements. All nursing staff will receive reeducation on the importance of working only on assigned hours and communicating any changes to one of the nurses on duty so that report can be updated. The posted report will include actual hours worked of all nursing staff including RNs, LPNs, CNAs, and NAs. To ensure compliance, random audits conducted by administrator/trained designee will be completed for 4 weeks, then monthly for 2 months. The results will be presented to the monthly QAPI committee for input on whether to increase, decrease, or discontinue audits. Compliance date 03/12/2025	

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F 732	Continued From page 4 handwritten notation in the box "1 RN +" without further information and two NA's for a total of 8 hrs. The 10:30 p.m. to 7:00 a.m. shift identified in the LPN box a zero with a line crossed through with a hand notations " 1 RN" without further information and one NA for a total of 4 hrs but did not identify what the shift worked for those 4 hrs. Further, the posting failed to identify the staff hours worked due to call-ins, vacations and/or staff shortages. The working schedule for 2/4/25, identified from 6:00 a.m. to 2:30 p.m. there was one LPN, one RN and two NA's from 2:15 p.m. to 10:45 p.m. there were two LPNs and two NAs, from 10:30 p.m. to 7:00 a.m. there was one LPN [10:30 p.m. to 3:00 a.m.] and one RN [from 3:00 a.m. to 7:30 a.m.] and one NA. During an interview on 2/4/25 at 12:07 p.m., the DON stated it was the staffing coordinator's responsibility to ensure the posting was available and updated as needed. DON stated when the staff coordinator was out it was her responsibility to ensure it was printed out of OnShift (a staff program for computer) and posted Once the posting was posted it should be updated as changes occur. On 2/2/25, the DON was working and stated she was responsible for the posting and did not update it with changes or call-ins, as she just did not have time. During an interview on 2/4/25 at 1:18 p.m., the staffing coordinator stated it was her responsibility to ensure the daily staff posting was done. If she was going to be gone or for the weekends, she made sure all the current information is in OnShift and print them off to be posted on the correct days. Some of the postings looked different as when they were printed from OnShift, sometimes the RN column was missing. The staffing	F 732		

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F 732	Continued From page 5 coordinator did not know how to get it to show up. When the staffing daily posted, she always checks to ensure the census is updated on the form; however, if there were call ins or schedule changes, she did not update the staff posting during the day. The staffing coordinator was not aware the staff posting would need to be update and reflect the correct shift and hours The facility was always filling empty shift through the day. During an interview on 2/5/25, at 11:04 a.m., the administrator stated it was the expectation the daily staff posting would be accurate. The facility's Nurse Staff Daily Posting Requirements dated 12/2/24, identified it is important to keep the report updated by making staffing changes as they occur.	F 732		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by	F 801		3/11/25

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F 801	Continued From page 6 a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or	F 801		

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F 801	Continued From page 7 D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dietary staff were educated on the required dishwasher tempuratures for 4 of 5 staff (cook (CK)-A, dietary aide (DA)-A, DA-B, DA-C, dietary manager (DM) who used the dishwasher. This had the potential to affect all 26 residents who consumed foods from the kitchen. Findings include: On 2/2/25 at 11:31 a.m., an initial kitchen tour was completed with dietary aide (DA)-A. A single commercial dishwasher was observed along the wall. Two gauges were located on the top front of the dishwasher. One gauge was labeled wash,	F 801	F801- Qualified Dietary Staff All food and nutrition employees have completed education on the required dishwasher temperatures and will continue education on dishwasher manufactured instructions on February 27th, 2025, for the specific equipment model for safe sanitization of dishes. All residents have the potential to be affected by this practice. As a result, all dietary staff have been trained on the required dishwasher temperatures. To ensure systemic changes are sustained, the dietary manager/designee	

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	245476	A. BUILDING _____ B. WING _____	02/05/2025

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F 801	Continued From page 8 and the other was labeled rinse. DA-A stated she would run dishes through a cycle, then monitor and document the highest temperatures of the wash and rinse cycles. Staff documented the temperatures three times daily on the temperature log. DA-A stated the wash temperature was okay and reached a minimum of 160 degrees, but the minimum rinse temperature was supposed to be 180 degrees and the tempurare had been running low, ranging 173-178, since January 2025. DA-A stated she was unaware what the numbers meant and had not been given direction on what to do other than to document the numbers. The Dish Machine Temperature Log(s) were reviewed and identified the following: - January 1, 2025, through February 2, 2025, the dishwasher rinse temperature was recorded between 164 degrees and 176 degrees and reached the minimum of 180 degrees 4 times during the date range. - December 2024, identified 72 of 93 recorded dishwasher rinse temperatures were below 180 degrees when monitored for the three meals. - November 2024, identified 66 of 90 recorded dishwasher rinse temperatures were recorded below 180 degrees when monitored for the three meals. On 2/2/25 at 12:20 p.m., the dietary manager, (DM) stated during January 2025, the dishwasher had not been reaching the minimum rinse temperature and on 1/19/25, the repair man was contacted, and the thermostat was replaced. The dish machine was a hot water single machine and	F 801	educated all dietary staff on the facility policy for dishwasher temperatures and safe sanitization. Also, on February 27th the continued training on the dishwasher machine will be completed by all dietary staff on the manufactured instructions for the model of the specific equipment and dishwasher temperature requirements. To ensure compliance, the dietary manager/designee will audit three dishwasher temperatures weekly for 4 weeks to ensure that the temperatures are within the required range. All current staff will be audited once a month for three months on the temperature regulations and what to do if the temperature is not reading appropriately. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. Compliance date 03/11/2025	

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F 801	Continued From page 9 had a rinse brick for the sanitizer. Hot water flushed through a rinse brick and dissolved the appropriate amount of rinse needed to sanitize the dishes. DM stated the dishes were getting sanitized because the brick was getting smaller, and the dishes were hot when they came out. DM stated she had not rechecked the rinse temperature or the log after the repair man left, and thought the machine was functioning properly. DM stated she checked the rinse temperature on 1/31/25, and the temperature was above 180 degrees. DM informed the staff to continue checking the temperatures and if the rinse cycle went below 177 degrees to use the three-compartment sink process. DA stated she had not documented the observations or the discussions she had with the dietary staff. The DM was unable to identify the rinse cycle was supposed to reach a tempurature of 180 degrees F on the rinse cycle. The DM stated she was unaware how low the temperatures had gotten when she reviewed the tempurature logs. DM reviewed the February temperature log which indicated the final rinse temperatures of 172 through 174. DM stated she informed her staff to monitor the rinse temperatures and if the temps were below 177 degrees, then use the three compartment sinks. On 2/4/25 at 12:16 p.m., DA-C stated her primary job was washing dishes. The final rinse temperature was checked three times daily, once at each meal. DA-C stated she ran dishes through the wash machine, monitored the gauges and documented the highest temperature reached during the wash and rinse cycles. DA-C stated she was uncertain if they used the three compartment sinks during the month of January because the tile was ripped up over by the sink	F 801		

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F 801	Continued From page 10 and could not remember if they used the sinks during that time. - DA-B approached the conversation and stated she washed the dishes one evening shift per week and documented the highest wash and rinse temperature during the cycle. DA-B stated she had not been given direction of what to do if the rinse temperatures were below 180 degrees and had not known when they would use the three sinks unless the dishwasher was broken. On 2/4/25 at 1:34 p.m., the administrator stated she took the Basics of Food Safety in Long Term Care Facilities online training that the staff were required to take. The administrator stated the training did not specifically identify what temperature's the dishwasher needs to reach; however, the log does identify the minimum temperatures for rinsing. On 2/5/25 at 8:54 a.m., DM stated she was not aware of the facility Warewashing-Mechanical and Manual- Food and Nutrition policy or the Mechanical Ware Washing Food and Nutritional Competency Checklist included in the policy. DM stated the staff completed the Basics of Food Safety in Long Term Care Facilities online coarse although the course did not include information regarding the importance of appropriate wash and rinse temperatures for the dishwasher. DM stated competency checklists for all dietary staff were not completed. The undated ECOLab Dishmachine ES-2000HT manufacturer's instructions identified the sanitizing rinse water minimum temperature of 180 degrees. The facility Warewashing-Mechanical and Manual	F 801		

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F 801	Continued From page 11 - Food and Nutrition policy reviewed 3/25/24, identified warewashing as the means to clean and sanitize utensils and food-contact surfaces of equipment. The policy identified food and nutrition employees were to ensure food preparation equipment, dishes and utensils were effectively cleaned, sanitized to destroy potential disease carrying organisms, and stored in a protective manner. The policy identified staff were to follow manufacturers instructions for the specific dishwasher model for minimum temperatures for safe sanitization of dishes as well as complete the Food and Nutrition Competency Checklist for mechanical warewashing.	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		3/11/25

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F 812	Continued From page 12 Based on observation, interview, and document review the facility failed to ensure the dishwasher rinse cycle reached or exceeded a tempurature to effectively sanitize dishes.This had the potential to affect 26 residents that consumed food from the kitchen. Findings include: On 2/2/25 at 11:31 a.m., an initial kitchen tour was completed with dietary aide (DA)-A. A single commercial dishwasher was observed along the wall. Two gauges were located on the top front of the dishwasher. One gauge was labeled wash, and the other was labeled rinse. DA-A stated she would run dishes through a cycle, then monitor and document the highest temperatures of the wash and rinse cycles. Staff documented the temperatures three times daily on the temperature log. DA-A stated the wash temperature was okay and reached a minimum of 160 degrees, but the minimum rinse temperature was supposed to be 180 degrees and the tempurare had been running low, ranging 173-178, since January 2025. DA-A stated she was unaware what the numbers meant and had not been given direction on what to do other than to document the numbers. The Dish Machine Temperature Log(s) were reviewed and identified the following: - January 1, 2025, through February 2, 2025, the dishwasher rinse temperature was recorded between 164 degrees and 176 degrees and reached the minimum of 180 degrees 4 times during the date range. - December 2024, identified 72 of 93 recorded	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. The dishwasher machine was replaced with a new thermostat by a contracted company. 2. All residents have the potential to be affected by this practice. Staff were reeducated that if the temperature is not reaching a sufficiently high temperature, they will use the 3 compartment sink to wash dishes. Staff was also reeducated on how to wash dishes in the 3 compartment sink. 3. To ensure systemic changes are sustained, the dietary manager/designee educated all dietary staff on the facility policy for dishwasher temperatures and safe sanitization. Including the expectation that they contact EcoLab (who we contract with for the leasing and maintenance of the dishwashers) directly or contact the dietary manager or her designee (who will in turn contact EcoLab) in the event the dishwasher is not maintaining appropriate temperatures. A sign has been added next to the dishwasher with directions to call the EcoLab 24/7 repair line if the dishwasher is not maintaining temperatures and to wash dishes in the 3 compartment sink. Also, the contracted company for the dishwasher machine, put in a new thermostat. All dietary staff will be educated on the new changes to ensure the problem does not recur.	

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F 812	Continued From page 13 dishwasher rinse temperatures were below 180 degrees when monitored for the three meals. - November 2024, identified 66 of 90 recorded dishwasher rinse temperatures were recorded below 180 degrees when monitored for the three meals. On 2/2/25 at 12:20 p.m., the dietary manager, (DM) stated during January 2025, the dishwasher had not been reaching the minimum rinse temperature and on 1/19/25, the repair man was contacted, and the thermostat was replaced. The dish machine was a hot water single machine and had a rinse brick for the sanitizer. Hot water flushed through a rinse brick and dissolved the appropriate amount of rinse needed to sanitize the dishes. DM stated the dishes were getting sanitized because the brick was getting smaller, and the dishes were hot when they came out. DM stated she had not rechecked the rinse temperature or the log after the repair man left, and thought the machine was functioning properly. DM stated she checked the rinse temperature on 1/31/25, and the temperature was above 180 degrees. DM informed the staff to continue checking the temperatures and if the rinse cycle went below 177 degrees to use the three-compartment sink process. DA stated she had not documented the observations or the discussions she had with the dietary staff. The DM was unable to identify the rinse cycle was supposed to reach a tempurature of 180 degrees F on the rinse cycle. The DM stated she was unaware how low the temperatures had gotten when she reviewed the tempurature logs. DM reviewed the February temperature log which indicated the final rinse temperatures of 172 through 174. DM stated she informed her staff to	F 812	4. To ensure compliance is sustained, the manager/designee will audit dishwasher temperature logs 3 times a week for four weeks. Then weekly for a month. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. Compliance date 03/11/2025	

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F 812	Continued From page 14 monitor the rinse temperatures and if the temps were below 177 degrees, then use the three compartment sinks. The infection control logs were reviewed from November through February and did not identfiy and gastrointestinal illness' and or outbreaks. Review of the service call summary forms identified the following: - 12/12/24: Regular Service Call - Rinse temperature of 178 degrees. - 1/13/25: Regular Service Call - Replaced temperature gauges that were not functioning properly. Rinse temperature before and after replacement at 180 degrees. - 2/3/25 Extra Service Request - Machine not hitting rinse temperature. Comments: Fixed stuck thermostat. A joint interview was completed with cook (CK)-A, DA-C and DA-B on 2/4/25 at 12:16 p.m.. CK-A stated she did not wash the dishes and prior to today was uncertain what the minimum rinse temperature should be. DA-C stated her primary role was washing dishes. DA-C stated she checked and documented the wash and rinse temperatures once per meal. DA-C stated she thought they had used the three compartment sink previously when the dish machine wasn't reaching minimum temperature. DA-C unable to remember the last time they used the three compartment sinks but thought it may have been in January 2025. DA-B stated she washed dishes one evening per week and checked the wash and rinse temperatures once during that meal. DA-B stated she wouldn't know what to do other than use the dishwasher, had not been directed to do anything differently and didn't know when they	F 812		

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F 812	Continued From page 15 would use the three-compartment sinks. On 2/5/25 at 9:02 a.m., the maintenance/ ancillary services supervisor (MAINT) stated on 1/13/25, the dishwasher was not getting up to temperature. The repair mas was contacted and replaced the gauges. After that the dish machine was reaching temperature. Then on 2/2/25, DM reported the dish machine was not reaching temperature and contacted the repair man again. They came out on 2/3/25 and said the thermostat was stuck, they fixed it, and the dishwash machine had been reaching temperature since. The facility Warewashing-Mechanical and Manual - Food and Nutrition policy reviewed 3/25/24, identified warewashing as the means to clean and sanitize utensils and food-contact surfaces of equipment. The policy identified food and nutrition employees were to ensure food preparation equipment, dishes and utensils were effectively cleaned, sanitized to destroy potential disease carrying organisms, and stored in a protective manner. The policy identified staff were to follow manufacturers instructions for the specific dishwasher model for minimum temperatures for safe sanitization of dishes as well as complete the Food and Nutrition Competency Checklist for mechanical warewashing.	F 812		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 18, 2025

Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue
Pine River, MN 56474

Re: State Nursing Home Licensing Orders
Event ID: 1VT211

Dear Administrator:

The above facility was surveyed on February 2, 2025 through February 5, 2025 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/2/25 through 2/5/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "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.	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the dishwashers rinse cycle reached or exceeded a tempurature to effectively sanitize dishes.This had the potential to affect 26 residents that consumed food from the kitchen. Findings include: On 2/2/25 at 11:31 a.m., an initial kitchen tour was completed with dietary aide (DA)-A. A single commercial dishwasher was observed along the wall. Two gauges were located on the top front of the dishwasher. One gauge was labeled wash, and the other was labeled rinse. DA-A stated she would run dishes through a cycle, then monitor and document the highest temperatures of the wash and rinse cycles. Staff documented the temperatures three times daily on the temperature log. DA-A stated the wash temperature was okay and reached a minimum of	21015	Corrected	3/11/25

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	00058	A. BUILDING: _____ B. WING _____	02/05/2025

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21015	Continued From page 3 160 degrees, but the minimum rinse temperature was supposed to be 180 degrees and the tempurare had been running low, ranging 173-178, since January 2025. DA-A stated she was unaware what the numbers meant and had not been given direction on what to do other than to document the numbers. The Dish Machine Temperature Log(s) were reviewed and identified the following: - January 1, 2025, through February 2, 2025, the dishwasher rinse temperature was recorded between 164 degrees and 176 degrees and reached the minimum of 180 degrees 4 times during the date range. - December 2024, identified 72 of 93 recorded dishwasher rinse temperatures were below 180 degrees when monitored for the three meals. - November 2024, identified 66 of 90 recorded dishwasher rinse temperatures were recorded below 180 degrees when monitored for the three meals. On 2/2/25 at 12:20 p.m., the dietary manager, (DM) stated during January 2025, the dishwasher had not been reaching the minimum rinse temperature and on 1/19/25, the repair man was contacted, and the thermostat was replaced. The dish machine was a hot water single machine and had a rinse brick for the sanitizer. Hot water flushed through a rinse brick and dissolved the appropriate amount of rinse needed to sanitize the dishes. DM stated the dishes were getting sanitized because the brick was getting smaller, and the dishes were hot when they came out. DM stated she had not rechecked the rinse temperature or the log after the repair man left,	21015		

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21015	Continued From page 4 and thought the machine was functioning properly. DM stated she checked the rinse temperature on 1/31/25, and the temperature was above 180 degrees. DM informed the staff to continue checking the temperatures and if the rinse cycle went below 177 degrees to use the three-compartment sink process. DA stated she had not documented the observations or the discussions she had with the dietary staff. The DM was unable to identify the rinse cycle was supposed to reach a tempurature of 180 degrees F on the rinse cycle. The DM stated she was unaware how low the temperatures had gotten when she reviewed the tempurature logs. DM reviewed the February temperature log which indicated the final rinse temperatures of 172 through 174. DM stated she informed her staff to monitor the rinse temperatures and if the temps were below 177 degrees, then use the three compartment sinks. The infection control logs were reviewed from November through February and did not identfiy and gastrointestinal illness' and or outbreaks. Review of the service call summary forms identified the following: - 12/12/24: Regular Service Call - Rinse temperature of 178 degrees. - 1/13/25: Regular Service Call - Replaced temperature gauges that were not functioning properly. Rinse temperature before and after replacement at 180 degrees. - 2/3/25 Extra Service Request - Machine not hitting rinse temperature. Comments: Fixed stuck thermostat. A joint interview was completed with cook (CK)-A, DA-C and DA-B on 2/4/25 at 12:16 p.m.. CK-A stated she did not wash the dishes and	21015		

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21015	Continued From page 5 prior to today was uncertain what the minimum rinse temperature should be. DA-C stated her primary role was washing dishes. DA-C stated she checked and documented the wash and rinse temperatures once per meal. DA-C stated she thought they had used the three compartment sink previously when the dish machine wasn't reaching minimum temperature. DA-C unable to remember the last time they used the three compartment sinks but thought it may have been in January 2025. DA-B stated she washed dishes one evening per week and checked the wash and rinse temperatures once during that meal. DA-B stated she wouldn't know what to do other than use the dishwasher, had not been directed to do anything differently and didn't know when they would use the three-compartment sinks. On 2/5/25 at 9:02 a.m., the maintenance/ ancillary services supervisor (MAINT) stated on 1/13/25, the dishwasher was not getting up to temperature. The repair mas was contacted and replaced the gauges. After that the dish machine was reaching temperature. Then on 2/2/25, DM reported the dish machine was not reaching temperature and contacted the repair man again. They came out on 2/3/25 and said the thermostat was stuck, they fixed it, and the dishwash machine had been reaching temperature since. The facility Warewashing-Mechanical and Manual - Food and Nutrition policy reviewed 3/25/24, identified warewashing as the means to clean and sanitize utensils and food-contact surfaces of equipment. The policy identified food and nutrition employees were to ensure food preparation equipment, dishes and utensils were effectively cleaned, sanitized to destroy potential disease carrying organisms, and stored in a protective manner. The policy identified staff were to follow	21015		

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21015	Continued From page 6 manufacturers instructions for the specific dishwasher model for minimum temperatures for safe sanitization of dishes as well as complete the Food and Nutrition Competency Checklist for mechanical warewashing. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure staff know and are monitoring the dishwasher for appropriate sanitizing temperatures. The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance	21426		3/11/25

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21426	Continued From page 7 regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a tuberculosis (TB) screenings was completed prior to working with residents for for 2 of 5 employees, (licensed practical nurse (LPN)-A and LPN-B; and failed to ensure either a ensure tuberculin skin testing (TST) and/or an IGRA (test used to determine presence of tuberculosis) was completed prior working with residents for 1 of 5 employees (LPN-A) reviewed for tuberculosis. Findings include: The following employee files identified the following: - LPN-A was hired 12/10/24. The employee file lacked a baseline TB screening and tuberculin skin testing and/or an IGRA. - LPN-B was hired 11/15/24. The employee file lacked a baseline TB screening. During an interview on 2/5/25 at 8:13 a.m., the administrator stated they were not able to find the TB screening form for LPN-A and LPN-B. Upon hire all staff were required to do a baseline TB screening and either a TST or lab test to check	21426	corrected	

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21426	Continued From page 8 their status. The employees are expected to complete those on hire. The facility's Tuberculosis Control Plan and Screening for Employees dated 1/31/25, identified prior to or upon hire, all employees will be screened for TB and will receive a base line TST and or TB blood test. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review current CDC guidelines for tuberculosis control within health care facilities, audit resident and staff for requirements, update/complete any steps missing and complete ongoing monitoring of new admissions and new hires to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21426		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/06/2025. At the time of this survey, Good Samaritan Society-Pine River was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 02/26/2025

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

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Good Samaritan Society of Pine River is a 1-story building with two basements. The building was constructed at five different times. In 1961 the nursing home was built and was determined to be of Type II(111) construction without a basement. In 1968 an addition was constructed to the north of the original building, that was determined to be of Type II(111) construction and has a basement. In 1985 an addition was constructed to the southwest of the 1961 building that was determined to be of Type II(111) construction and

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K 000	Continued From page 2 has a partial basement. In 1993 an addition was constructed to the west of the 1985 addition that was determined to be of Type II(111) construction. In 1996 the last addition was added to the west of the 1993 addition that was determined to be of Type II(111) construction. The building is divided into 7 smoke zones by one and two hour fire barriers. The facility is separated by 2-hour fire barriers form an outpatient physical therapy building. The facility is fully fire sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 33 beds and had a census of 24 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient finding	K 281	K281 1. The maintenance supervisor audited all emergency exit outside light fixtures for two forms of illumination on 2/10/2025.	2/10/25

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K 281	Continued From page 3 could have an isolated impact on the residents within the facility. Findings include: On 02/06/2025 between 09:00am and 1:00pm, It was revealed by observation that the exterior lights for emergency exit for the Oak Wing had only one bulb for illumination. Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2.2 lux) in any designated area. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 281	2. Two forms of illumination were installed outside of the emergency exit light fixture on oak hallway on the date of 2/10/2025.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to maintain emergency lighting system per NFPA 101 (2012 edition), Life Safety Code sections 19.2.9.1 and 7.9.1.3. This deficient practice could have a patterned impact on the residents within the facility. Findings include: On 02/06/2025 between 09:00am and 1:00pm, it was revealed by observation that the facility failed to conduct the annual 90 minute required	K 291	K291 1. The maintenance supervisor located the 90-minute annual light testing paperwork on 2/10/2025. 2. The annual light testing was put into the proper location in the LSC book.	2/10/25

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K 291	Continued From page 4 Emergency Lighting test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced	K 321		2/10/25

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K 321	Continued From page 5 by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a isolated impact on the residents within the facility. Findings include: On 02/06/2025 between 09:00am and 1:00pm, it was revealed by observation that wheelchair / storage room did not have a self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	K321 1. The maintenance supervisor purchased and installed a self-closing device on the door of the wheelchair/storage room. 2. On the date of 2/10/2025, the wheelchair/storage room self-closing hinges were tested to ensure compliance.	
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code section 14.2.1.2.2. These deficient findings could have a patterned impact	K 345	K345 1. The 2024 annual fire alarm system testing was completed on 2/29/2024 by Northland Fire. 2. Northland Fire was contacted on 2/7/2025 to complete the facilities annual sensitivity testing for the fire alarm system	2/14/25

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K 345	Continued From page 6 on the residents within the facility. Findings include: On 02/06/2025 between 09:00am and 1:00pm, it was revealed by a review of available documentation that the annual fire alarm inspection report produced by Northland dated 02/29/2024 that the facility could not provide documentation that a sensitivity testing had been conducted. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	for 2025. 3. Northland Fire reviewed and completed the facilities annual sensitivity testing for the fire alarm system on 2/14/2025. 4. Administrator and Maintenance supervisor worked with the program system TELS to ensure the annual fire alarm system testing is tracked moving forward.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		2/17/25

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	245476	A. BUILDING **01 - 1985 BUILDING AND ADDITIONS** B. WING _____	**02/06/2025**

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K 353	Continued From page 7 by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/06/2025 between 09:00am and 1:00pm, it was revealed by a review of available documentation the facility failed to perform the five (5) year sprinkler system testing. Last documented 5 tear test was dated 01/13/2020 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	K353 1. Breth Zen-Zen was contacted on 2/7/2025 to complete the facilities 5-year fire sprinkler system and standpipe testing. 2. Breth Zen-Zen reviewed and completed the facilities 5-year fire sprinklers system and standpipe testing on 2/17/2025. 3. Administrator and Maintenance supervisor worked with the program system TELS to ensure the 5-year testing is tracked moving forward.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These	K 363		2/11/25

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K 363	Continued From page 8 requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 02/06/2025 between 09:00am and 1:00pm, it was revealed by observation that Mechanical room on Oak wing, Soiled Utility room on Oak	K 363	K363 1. The maintenance supervisor reviewed all mechanical and soiled utility rooms to ensure all doors latch on 2/11/2025. 2. All mechanical and soiled utility room hinges were adjusted to ensure closure and latching on the date 2/11/2025.	

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K 363	Continued From page 9 wing did not latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 363		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 02/06/2025 between 09:00am and 1:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above Fire doors located outside of Mail-room and Fire doors between Oak	K 372	K372 1. Fire caulking that withstands fire for up to 4 hours was added to the following smoke compartments on 2/11/2025: a. Door by Mailroom b. Door between oak and cedar wing 2. The preventative Maintenace program and instructions have been updated to include monthly checks for 4 months. Following the monthly checks of four months, the caulking will be checked annually.	2/11/25

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K 372	Continued From page 10 and Cedar wing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372		
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. (5), (6), (7), and/or (8) These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/06/2025 between 09:00am and 1:00pm, it was revealed in a review of available documentation that the facility's fire s safety plan did not include a facility drawing of fire wall/	K 711	K711 1. The maintenance supervisor and administrator reviewed and updated the evacuation and relocation plan in the emergency management book on 2/12/2025. 2. The smoke compartments were labeled on the facility evacuation and relocation plan for the emergency management plan on 2/12/2025.	2/12/25

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K 711	Continued From page 11 smoke wall and or smoke partitions. An facility drawing is need to instruct staff on where to isolate patients from fire, horizontal evacuation from one smoke compartment to another and/or preparation of floors and building for evacuation. An interview with the Director of Maintenance verified these deficient findings at the time of discovery	K 711		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 920		2/13/25

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K 920	Continued From page 12 Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/06/2025 between 09:00am and 1:00pm, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the Oak Wing Breakroom. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	K920 1. The maintenance supervisor removed the power strip from the Oak staff breakroom on 2/13/2025. 2. The maintenance supervisor reviewed downstairs break rooms to ensure no other power strips were present on 2/13/2025. 3. The maintenance supervisor educated all staff that electrical appliances cannot be plugged into power strips, multi-plug adapters and/or extension cords on 2/13/2025.	