DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 67YE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00058

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245476**
2.STATE VENDOR OR MEDICAID NO.
(L2) **017040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - PINE RIVER**
(L4) **518 JEFFERSON AVENUE, PO BOX 29**
(L5) **PINE RIVER, MN** (L6) **56474**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/23/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **33** (L18)
13.Total Certified Beds **33** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	33			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, Unit Supervisor 12/06/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/31/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00140 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
01/05/2022 (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 6, 2022

CMS Certification Number (CCN): 245476

Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue, Po Box 29
Pine River, MN 56474

Dear Administrator:

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

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

Effective November 23, 2021 the above facility is certified for:

33 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 33 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
January 6, 2022

Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue, Po Box 29
Pine River, MN 56474

RE: CCN: 245476
Cycle Start Date: October 14, 2021

Dear Administrator:

On November 8, 2021, we notified you a remedy was imposed. On November 23, 2021 the Minnesota Department(s) 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 November 23, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 23, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from NO DATA due to denial of payment for new admissions. Since your facility attained substantial compliance on November 23, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Signature block here

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 67YE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L3) **GOOD SAMARITAN SOCIETY - PINE RIVER**
(L4) **518 JEFFERSON AVENUE, PO BOX 29**
(L5) **PINE RIVER, MN** (L6) **56474**

4. TYPE OF ACTION: **2** (L8)
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3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
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5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

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FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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	33			
(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date :
Dani Yuretic HFE - NE II 12/06/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/31/2021 (L20)

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____ 2. Facility is not Eligible (L21)

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22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
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25. LTC EXTENSION DATE:
(L27)

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(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
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06-Fail to Meet Agreement
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07-Provider Status Change
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28. TERMINATION DATE:
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29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 8, 2021

Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue, Po Box 29
Pine River, MN 56474

RE: CCN: 245476
Cycle Start Date: October 14, 2021

Dear Administrator:

On October 14, 2021, a survey was completed at your facility by the Minnesota Department(s) 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 23, 2021.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 23, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 23, 2021.

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

This Department is also recommending that CMS impose:

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 23, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Pine River will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 23, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 14, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	**518 JEFFERSON AVENUE, PO BOX 29 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 10/11/21 through 10/14/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/11/21 through 10/14/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5476024C (MN7645) with a deficiency issued at F689. The following complaint was found to be UNSUBSTANTIATED: H5476025C (MN77426) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/16/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 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
F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure survey results were placed in a prominent place and contained or directed where to obtain the last three years of survey results. This had the potential to effect all	F 577	Preparation and execution of this 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	10/29/21

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 _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 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
F 577	Continued From page 2 25 residents residing in the facility, along with family, visitors and staff. Findings include: During resident meeting on 10/13/21, at 10:38 a.m. R18 and R11 stated they did not know where the facility posted the survey results. During interview on 10/13/21, at 10:48 a.m. R6 stated she never noticed if the survey results were available and did not know where they are stored. On 10/14/21, at 9:48 a.m. licensed social worker (LSW) was asked where the facility survey results were kept for resident, family, visitors and staff to view. LSW walked over to the first nursing desk where there were a few binders on the edge of the desk, without labels on the binder edge. LSW pulled each binder out before identifying the survey results were in a white three ring binder. The front of the binder identified the facility survey results were in the binder; however, did not include the last three years of survey results from all abbreviated and recertification surveys. Further, the binder did not identify where to request the last three years of survey results. The binder contained the following survey results: - 9/9/20, from a focused infection control survey - 10/15/20, from a revisit survey - 2/3/21 - 2/4/21, from an abbreviated survey - 6/10/21, from an abbreviated survey - 9/8/21, from an abbreviated survey. During interview on 10/14/21, at 9:51 a.m. the administrator stated the administrator was responsible for placing the survey results in the	F 577	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. F577-C It is the policy of this facility to ensure the highest quality of care is afforded by our residents. Consistent with this practice the following has been done: 1.The center addressed the survey results deficiency on 10/13/2021. A binder was created, labeled, and put in a centralized location. 2.On 10/29/2021 the center contacted families and residents making them aware of the location of the survey results. 3.Information has been added to our entrance booklet which will allow all new residents and families to be aware of the results. 4.A sign has been placed above the nurse's station where the survey results are located. The book has been properly labeled with sufficient information inside. All staff will be educated on the location and significance of the survey results on 10/25/2021.	

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	245476	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 577	Continued From page 3 binder and was likely missed due to staff turnover. The facility policy Posting Information- Social Services dated 12/22/20 identified " All residents residing in the location have the right to be aware of certain location information concerning its operation, as well as their right of appeal and advocacy. It is the responsibility of the location to post this information in a visible place and keep it updated at all times. All postings must be legible and readable, and a magnifying glass needs to be available to assist those who are visually challenged. It is the responsibility of the social worker to keep abreast of what needs to be posted and post it accordingly. All information is to be accessible to all residents, whether ambulatory or in a wheelchair". The policy did not identify how many years of survey results were required to be available.	F 577	5.To monitor our performance to ensure that solutions are sustained, the administrator will conduct an audit with any survey activity to validate the survey results are noticeable and that residents are aware of the location. 6.Corrected by 10/29/2021	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		11/15/21

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F 584	Continued From page 4 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident toilet was clean for 1 of 1 residents (R1) reviewed who's family voiced concerns regarding an unclean toilet. Findings include: On 10/13/21, at 11:46 a.m. R1's family member (FM)-A stated R1's bathroom toilet was dirty. FM-A previously talked to staff about it and was still dirty today. The bathroom area was observed with FM-A. There was a dried unidentified	F 584	F584-D 1.R1□s toilet and bathroom were cleaned that day. Housekeeping staff was educated as to how to properly clean a restroom. All staff was educated on the importance of a clean environment to promote infection control. 2.All Residents are at increased risk of infection due to improper toilet cleaning. 3.All housekeeping staff were educated by	

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F 584	Continued From page 5 substance around the bolt covers at the base of the toilet seat and in the frame mount (used to secure the toilet seat arm rests to the toilet) of R1's toilet. During interview on 10/14/21, at 8:33 a.m. the supervisor of ancillary services (SAS) stated housekeeping cleaned the the resident bathroom and toilets every day. Housekeeping staff had not received specific training for cleaning resident toilets. SAS expected staff to clean the resident toilet daily and thought staff knew how to clean the toilets. The facilities Environmental Cleaning Principles policy revised 12/16/20, indicated environmental cleaning played an important role in the infection control program, and the spread of infections from contaminated surfaces was significant and supported the need for good procedures and practices related to cleaning and disinfecting of surfaces. All staff should be aware of the general principles of environmental cleaning and safety.	F 584	the ancillary services supervisor or director of nursing on how to clean a toilet using the Environmental Services Cleaning Guidebook. This guide will be used going forward to train housekeeping staff as to how to clean a bathroom. As well as all staff were educated as to the importance of reporting dirty bathrooms to housekeeping for cleaning. 4.Environmental Services Director or designee will audit 3 toilets 3 times a week for 6 weeks to ensure that they are being cleaned correctly. They will report their findings to the QAPI committee after which the results of the audits will be reviewed by the QAPI committee, and they will give direction for any further needed action. 5.Corrected by 11/15/2021	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		11/12/21

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F 610	Continued From page 6 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse was thoroughly investigated to prevent further or ongoing abuse for 1 of 1 residents (R3) reviewed who had abuse allegations against a staff member. Findings include: R3's quarterly Minimum Data Set (MDS) dated 7/20/21, identified R3 had moderate cognitive impairment, required assistance with bed mobility, toileting and transfers and had not exhibited physical or verbal behaviors. R3's diagnoses included cerebral vascular accident (stroke), right hemiplegia (paralysis of one side of the body) and hemiparesis (partial weakness of one side of the body). The incident report submitted to the state agency (SA) on 10/6/21, at 4:09 p.m. indicated the incident occurred on 10/6/21. The report identified R3 had reported nursing assistant (NA)-C picked up his pillow off the floor and threw it in his face. The Investigation Status Report Summary submitted to the SA on 10/8/21, identified the facility was unable to substantiate the allegation of abuse; however the summary lacked interviews from other residents regarding potential staff to resident abuse.	F 610	F610-D 1.Investigator immediately trained on the importance of interviewing not only additional staff but also additional residents during investigations of abuse allegations. 2.All residents are at risk of having investigation of their welfare not being performed in a way that investigates all side. All investigations conducted in the last three months have been reviewed to ensure thorough investigation was conducted. All were found to be in compliance. 3.All staff that preform investigations of abuse allegations were educated by the administrator as to the importance of interviewing not only additional staff but also additional residents during investigations of abuse allegations. Good Samaritan Society policy and procedure for abuse and neglect investigations was reviewed and deemed appropriate. All staff responsible for conducting investigations have been re-educated on this process. 4.Administrator or designee will audit all	

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F 610	Continued From page 7 The facilities internal investigation notes identified FM-A reported the alleged abuse on 10/6/21. The notes indicated R3, FM-A, NA-C and licensed practical nurse (LPN)-D were interviewed and subsequently NA-C was placed on administrative leave pending further investigation. The documentation did not identify and other residents, other than R3, were interviewed regarding potential abuse by any staff member. During interview on 10/14/21, at 2:39 p.m. the interim director of nursing (DON) stated an abuse investigation would include interviews from the complainant, involved staff, and residents. If the concern involved a staff member, the specific staff member would be observed and depending on their work ethic, the facility may/may not interview more staff, families and/or other residents. Other residents were not interviewed because NA-C's observed interactions with residents and staff were positive and staff reported only good things regarding NA-C. The facilities Abuse and Neglect policy revised 12/23/20, indicated all incidents of alleged abuse were to be thoroughly investigated and staff were to prevent further potential abuse while the investigation was in process. The investigation may include interviewing employees, residents or other witnessed to the incident.	F 610	investigations of allegations of abuse over 6 weeks to ensure that not only additional staff, but also additional residents were interviewed during the investigations. They will report their findings to the QAPI committee after which the results of the audits will be reviewed by the QAPI committee, and they will give direction for any further needed action. 5.Corrected by 11/12/2021	
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's	F 623		11/12/21

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representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section

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must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

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F 623	Continued From page 10 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure written transfer notices were provided to the resident or resident representative and to the Long-Term Care Ombudsman following a facility-initiated transfer to the hospital for 2 of 2 residents (R23, R73) reviewed for hospitalization. This had the potential to affect all 25 residents residing in the facility. Findings include: R23's Progress Note dated 10/1/21, identified R23 was transferred to the hospital with weakness, confusion, labored breathing and wheezing and her representative was notified. The medical record lacked evidence written notice of the transfer was provided to R23 or her representative or Long-Term Care Ombudsman. R73's Progress Note dated 10/12/21, identified R73 was transferred to the hospital with shortness of breath and her representative had been notified and had approved a bed hold. The medical record lacked evidence written notice of the transfer was provided to R73 or her	F 623	F623□C 1.All notices of transfer and discharge were sent out for the month of October to all resident or their representative as well as the Ombudsman. 2.All residents are at risk of being inappropriately discharged or transferred by not receiving notice for themselves or their representative as well as the Ombudsman. All residents discharged or transferred in the last thirty days were reviewed and none were found to be non-compliant. 3.All staff that may send out notices of transfer and discharge have been educated as to the requirement to send out transfer and discharge notices to the resident or their representative as well as the Ombudsman. 4.All transfers and discharges will be audited monthly for 3 months by the social services director or their designee. They	

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F 623	Continued From page 11 representative or Long-Term Care Ombudsman. . During interview on 10/14/21, at 3:04 p.m. business office manager (BOM) stated she completed the transfer notice forms for R23 and R73 and scanned them into their medical records. She then opened R23's electronic record and displayed the completed form. However, BOM stated she only completed the form and scanned it into the record. She did not do anything else with the document. She had not provided the documents to the resident, resident representative, or to the Long- Term Care Ombudsman. During interview on 10/14/21, at 3:16 p.m. the health information manager (HIM) and registered nurse (RN)-A both stated they had not provided notices of transfer to either the resident, resident representative, or the Long-Term Care Ombudsman. HIM stated a previous director of nursing (DON), who no longer worked at the facility, changed the facility processes for transfer notices and the notices were not sent to the required individuals. The system was broken long enough that she could not remember the last time it was done. HIM provided a report which identified 14 residents were transferred to the hospital and/or the emergency department a total of 20 times since 7/1/21 and stated notices were not provided to the residents, representatives, or Long- Term Care Ombudsman for any of the identified facility-initiated transfers. During interview on 10/1421 at 4:31 p.m. the interim DON stated the facility should have notified the resident or resident representative and ombudsman regarding facility-initiated transfers as required.	F 623	will report their findings to the QAPI committee after which the results of the audits will be reviewed by the QAPI committee, and they will give direction for any further needed action. 5.Corrected by 11/12/2021	

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F 623	Continued From page 12 The Discharge and Transfer-Rehab/Skilled, Therapy & Rehab policy dated 12/29/20, identified when a resident was temporarily transferred on an emergency basis to an acute care center, this type of transfer was considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable. Copies of notices for emergency transfers must also be sent to a representative of the Office of the State Long-Term Care Ombudsman, but they may be sent when practicable.	F 623		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement identified interventions to minimize the risks for falls for 1 of 2 residents (R12) reviewed for falls. Findings include: R12's quarterly Minimum Data Set (MDS) dated 9/7/21, identified R12 had severe cognitive impairment and diagnoses which included dementia, anxiety disorder, spondylolisthesis (disorder of the spinal cord in which one vertebra	F 689	F689-D 1.Fall interventions prescribed by the IDT were put into place immediately upon surveyors notifying staff that they had not been for R12. 2.All residents are at risk for proper interventions not being in place to ensure their safety. All residents having had a fall in the last thirty days have been reviewed and care plans updated as appropriate.	11/16/21

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F 689	Continued From page 13 slips onto the vertebra below it), chronic pain, lumbar spinal stenosis (condition where spinal column narrows and compresses the spinal cord), arthritis, and age-related osteoporosis. The MDS identified R12 required supervision with transfers, toilet use, walking in her room and locomotion on/off the unit and required limited assistance with walking in the corridor. Further, R12 had not experienced any falls since the previous assessment period. R12's care plan dated 6/8/21, identified R12 was at risk for falls related to severe lumbar stenosis, pain, arthritis, cognitive impairment, self-transfers, poor safety awareness, anxiety, incontinence, history of malnutrition, removed non-slip footwear on own, and impulsiveness as evidenced by a history of fall at previous skilled nursing facility attempting to throw self on floor and falls related to self-transfers. The care plan directed staff to implement interventions which included to ensure R12 wore appropriate, non-slip footwear when transferring, ambulating, or mobilizing in wheelchair, keep wheelchair next to bed when R12 was in bed, auto-lock brakes on wheelchair, and grip strips on floor next to bed, toilet, and sink. The care plan did not address grip strips in front of dressers. R12's incident report dated 10/4/21, identified at 6:11 a.m. R12 was found on the floor sitting on her buttocks next to the bed and had used the call light to alert staff. R12 stated she was at the end of the bed trying to get the dresser drawer open. R12's wheelchair was at the end of the bed in front of the dresser. R12 experienced a bruise and skin tear to her left knee and a laceration to her face.	F 689	3.The facility has created a fall committee that will meet the business day following the IDT teams discussion of the fall to ensure that all interventions decided upon by the IDT were implemented. The discussion will include implementing a team or department to follow through with interventions. 4.On 10/25/21 all staff was educated on the significance and requirement to follow all fall interventions. Staff is to notify the IDT if interventions are not being followed. 5.DON or designee will audit all falls over 6 weeks to ensure interventions were put in place the day of the IDT teams meeting. They will report their findings to the QAPI committee after which the results of the audits will be reviewed by the QAPI committee, and they will give direction for any further needed action. 6.Corrected by 11/16/2021	

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R12's Progress Note dated 10/4/21, identified the Falls committee reviewed R12's fall from 10/4/21 at 6:11 a.m. R12 was found sitting on the floor next to her bed and had used her call light to alert staff. R12 stated she had been "at the end of the bed trying to get open the dresser drawer." R12's wheelchair was noted to be at the end of the bed near the dresser. R12 had apparently been sitting in the wheelchair, going through her dresser when she fell forward and then scooted herself over to the bed to use the call light. R12 was wearing gripper socks at the time of the fall. R12 was noted to frequently self-transfer and ambulate around her room without assistance or use of a walker. She did not remember staff's frequent reminders to call for assistance, instead did things on her own or refused staff assistance. Current fall interventions included: STOP signs in room. Keep wheelchair next to bed when in bed. Auto-lock brakes on wheelchair. Grip strips on floor next to bed, toilet, and sink.

- The fall committee determined a new intervention to add grip strips to the floor in front of the dresser as R12 tended to stand at the dresser. They also determined to see if R12's room could be rearranged to have 2 short dressers in place of the one tall dresser to make it easier for her to look through the dresser. They also ordered a PT [physical therapy] screening, however felt as R12 had experienced no change in mobility, it was not likely she would require any therapy orders. No further fall interventions were identified.

R12's Falls Tool dated 10/4/21, identified R12 was a medium risk for falls.

During observation on 10/12/21, at 7:44 p.m. R1

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F 689	Continued From page 15	F 689		

was seated in a wheelchair in her room. The overhead lights were off, and a table lamp was on while R12 watched television. Non-slip strips noted on floor in front of bed and in front of the toilet. Two three-drawer dressers were positioned side by side on the wall under the television on the end of the bed; however, no non-slip strips noted to floor in front of the dressers.

During observation on 10/13/21, at 9:47 a.m. R12 wheeled herself out of the bathroom in her room in her wheelchair. The wheelchair had auto-locking brakes. Non-slip strips were affixed to the floor in the bathroom and ran the length of the floor from in front of the toilet to in front of the sink. R12 was well groomed and wore slip-on loafers without socks. No non-slip strips were noted on the floor in front of the dressers in R12's room.

During interview on 10/14/21 at 9:56 a.m. nursing assistant (NA)-E stated R12 required fall interventions such as auto-locking brakes on her wheelchair. She also checked on her every fifteen to thirty minutes as R12 liked to keep her door shut. R1 had skid strips next to her bed and in her bathroom and was not aware of placement of the skid strips anywhere else.

During interview on 10/14/21, at 3:20 p.m. registered nursing (RN)-A stated the interdisciplinary team (IDT) met and reviewed resident falls to determine if any new interventions could be identified. She then documented a note regarding the review and ensured the care plan was updated and indicated this was usually done at the time of the IDT meeting. Care staff was then updated regarding

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F 689	Continued From page 16 the changes. Regarding R12's 10/14/21 fall, PT completed a screening and R12 had not met criteria for services. Her tall dresser was replaced with two short dressers. RN-A was not sure if the grip strips were supplied and stated these should have been documented in the maintenance book for the maintenance staff to apply to the floor. -At 3:25 p.m. R12's room was reviewed with RN-A and she stated the strips should be on the floor in front of R12's dresser and were not. During interview on 10/14/21, at 4:34 p.m. the interim director of nursing (DON) stated she would expect identified interventions to minimize falls be implemented. The Fall Prevention and Management - Rehab/Skilled, Therapy & Rehab policy dated 9/17/21, directed staff one of the purposes of the fall prevention and management program was to identify risk factors and implement interventions before a fall occurred. If a resident sustained a fall, the policy directed staff to update the care plan with any changes/new interventions and monitor the resident's condition and the effectiveness of the interventions.	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		11/12/21

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F 880	Continued From page 17 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 18 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff wore N95 respirators for new admissions who were not fully vaccinated from COVID-19 for 1 of 1 residents (R174) who was on a 14- day new admission quarantine. In addition, the facility failed to ensure all staff wore appropriate eye protection when in resident care areas as directed by the Centers for Disease Control (CDC). This had the potential to effect all 25 residents residing in the facility, along with staff and visitors. Findings include: N95 RESPIRATORS: R174's admission Minimum Data Set (MDS) dated 8/14/21, included a diagnosis of a hip fracture and required assistance with activities of	F 880	F880-F 1.All staff were immediately re-educated on the requirement by GSS policy to wear appropriate eye protection (goggle or face shields) in resident care areas. All staff were immediately re-educated on the requirement by GSS policy to wear one time use N95 masks when in isolation rooms. 2.All residents are at risk of infection spread through improper use of eye protection and N95 PPE. 3.All staff were educated as to the requirement by GSS policy to use eye protection and N95s as appropriate to prevent the spread of infection. All staff	

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F 880	Continued From page 19 daily living including ambulation, locomotion, bed mobility and transfers. R174's medical record did not identify R174 was having any signs or symptoms of COVID-19, nor did the record identify R174 was fully vaccinated from COVID-19. During observation on 10/12/21, at 6:39 p.m. a transmission-based precautions (TBP) cart outside was outside of R174's room. The TBP cart included gowns, gloves and surgical face masks but did not include any N95 respirators. On 10/13/21, at 8:29 a.m. the COVID-19 testing room was observed. There was a wired shelving unit with five shelves that contained approximately 80 boxes of N95 respirators with 10 to 20 respirators per box. During observation on 10/13/21, at 8:53 a.m. NA-A wore a surgical face mask with a face shield covering NA-A's eyes and face mask. NA-A put on a pink washable gown and gloves and carried bed linens into R174's room. NA-A did not wear an N95 respirator. On 10/13/21, 9:06 a.m. NA-A stated R174 was on TBP because R174 was a new admission and was not fully vaccinated against COVID-19. NA-A pointed to a sign on the TBP cart outside of R174's room and stated staff were to wear a gown, gloves, a surgical face mask and a face shield when they entered R174's room. The sign on the cart outside R174's room directed staff to wear gown, gloves, eye protection and surgical mask. The sign did not direct staff to wear a N95 respirator.	F 880	were educated as to the proper use of eye protection and N95s. N95s were made available outside of all isolation rooms and management and staff who set up isolation rooms have been educated on the need to include N95s in the PPE cart for those rooms. Re-education and competencies were completed 10 11/17/21. 4.DON or designee will conduct routine observation audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on proper use of PPE by staff and source control masking for residents and visitors. They will report their findings to the QAPI committee after which the results of the audits will be reviewed by the QAPI committee, and they will give direction for any further needed action. 5.Corrected by 11/12/2021	

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On 10/13/21, at 11:38 a.m. physical therapy assistant (PTA)-A was observed seated face to face with R174 approximately 4 feet in front of R174. PTA-A was wearing a surgical face mask, face shield, gown and gloves. PTA-A stated R174 was a new admission and was on a 14-day quarantine. Staff were not required to wear an N95 respirator because R174 was not exposed to COVID-19.

During interview on 10/13/21, at 12:46 p.m. NA-A stated staff would wear an N95 respirator when they entered a COVID-19 positive or suspected positive resident's room. R174 was on TBP because he was a new admission and was unvaccinated. NA-A stated staff did not wear an N-95 respirator in R174's room.

During interview on 10/13/21, at 2:47 p.m. licensed practical nurse (LPN)-C stated R174 was on isolation precautions because he was a new admission and had not received a COVID-19 vaccination. Staff were expected to wear an N-95 respirator when they entered a COVID-19 positive resident's room.

During interview on 10/14/21, at 12:01 p.m. the interim director of nursing (DON) stated the facility did not have a shortage of N95 respirators and would say the facility was in conventional status for N95 respirators. She was not aware of the requirement to wear an N95 respirator if the resident was on a new admission quarantine status and was not displaying any signs or symptoms of COVID-19.

The facility provided COVID Standard Precautions sign dated 5/30/19, identified everyone entering needed to wear a gown, gloves

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and face protection. In addition, doctors and staff must wear appropriate mask, eye cover, gown and gloves if contact with body fluids was likely. The sign did not identify gowns, gloves, eye protection and N95 respirators needed to be worn at all times.

The facility policy Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-Enterprise revised 10/7/21, identified the facility could implement practices allowing for reuse and extended PPE only when there was a limited supply. Further, the policy identified for suspected or confirmed COVID-19 the staff would wear a N95 respirator respirator and a surgical mask was acceptable if no N95 respirators were available.

The CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes 9/10/21, identified all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission and an N95 respirator should be worn.

The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 9/10/21, identified, health care personal (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).

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The CDC's Strategies for Optimizing the Supply of N95 respirators dated 9/16/21, identified N95 respirators are the PPE most often used to control exposures to infectious pathogens transmitted via the airborne route, though their effectiveness is highly dependent upon proper fit and use. N95 respirators are intended to be used once and then properly disposed of and replaced with a new N95 respirator. The optimal way to prevent airborne transmission is to use a combination of interventions from across the hierarchy of controls, not just PPE alone. Applying a combination of controls can provide an additional degree of protection, even if one intervention fails or is not available

EYE PROTECTION:

On 10/13/21, at 7:16 a.m. LPN-E was standing at the medication cart setting up medications in the resident hallway. LPN-E was wearing prescription eye glasses with slide on plastic coverings on the bow of the glasses. The plastic created small gaps at the side and did not cover the eye area fully. LPN-E passed medications to multiple residents and multiple residents passed LPN-E in the hallway on the way to the dining room. LPN-E stated management instructed LPN-E they could use the eye shield coverings and was not aware the eye protection was not approved as personal protective (PPE) equipment.

During observation on 10/13/21, at 1:23 p.m. environmental services (EVS) was using a large carpet sweeper to sweep carpet along the main

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resident hallway. EVS walked the entire length of the hallway with eye protection glasses on the top of his head. Residents were in the area.

During observation on 10/14/21, at 11:24 a.m. EVS was standing in the resident hallway with his eye protection on top of his head and not covering his eyes. Residents were in the hallway.

During interview on 10/14/21, at 11:25 a.m. EVS stated he had been wearing his eye protection on top of his head in the resident hallways as he thought that was an acceptable practice.

During interview on 10/14/21, at 12:01 p.m. the interim DON stated approved eye protection (goggles or a faceshield) was to be worn in all resident care areas and especially when within six feet of other residents, to reduce the transmission of COVID-19.

The facility policy Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID)-Enterprise revised 10/7/21, identified eye protection (e.g., face shields, goggles) must be morn for all close contact with suspected or confirmed cases of COVID-19 in routine outpatient, acute, care and long term care. Eye protection was also recommended to be worn with droplet or enhanced droplet precautions. Further eye protection that covers both the front and sides of the face would be used.

The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 9/10/21, identified, health care personal (HCP) who enter the room of a patient with suspected or confirmed

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F 880	Continued From page 24 SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face).	F 880		

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/16/2021

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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	245476	A. BUILDING **01 - 1985 BUILDING AND ADDITIONS** B. WING _____	**10/14/2021**

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K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail 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. Inspected as one building: 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	K 000		

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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 25 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 345 SS=F	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	K 345	Preparation and execution of this	11/18/21

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K 345	Continued From page 3 and staff interview, the facility failed to test and 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, sections 14.5.2 and 14.6.2.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/14/2021, at 10:30 AM, during a review of all available fire alarm test and inspection documentation and an interview with Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that a semiannual inspection of all initiating devices had been completed. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 345	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. K345-F 1.The ancillary services supervisor performed visual inspection on all initiating devices on 10/16/21. The visual inspection included looking for damage, placement, and cleanliness in addition to looking for the light on the detector to flashing. Inspection was documented. 2.On 11/18/2021 Northland Fire completed our semiannual inspection. 3.A document was created and added to duty calendar of the ancillary services supervisor to serve as a reoccurring reminder of the need to complete this task going forward on a required basis. 4.The ancillary services supervisor will be responsible for correction and monitoring to prevent a reoccurrence of this deficiency.	

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K 345	Continued From page 4	K 345	5.Jeremy O□Neil, ancillary services supervisor 6.Corrected by: 11/18/2021	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to install and maintain the fire sprinkler system in accordance with NFPA 101 "Life Safety Code" 2012 edition, sections 8.3.5.6.3(3) and 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 6.2.7 and 8.16.1.1.8. These deficient findings could have a patterned impact on the residents within the facility.	K 351	K351-F 1.On October 14, 2021, the ancillary services supervisor installed a new escutcheon ring around the sprinkler head in the chapel lounge. 2.A document was created and added to duty calendar of the ancillary services	10/27/21

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K 351	Continued From page 5 Findings include: 1. On 10/14/2021 at 11:50 AM, it was revealed by observation that the fire sprinkler head located in the chapel lounge over the piano is missing an escutcheon ring. 2. On 10/14/2021 at 12:15 PM, it was revealed by observation that the fire sprinkler system riser did not have the control valves properly identified and labeled. An interview with Maintenance Supervisor verified these deficient findings at the time of discovery.	K 351	supervisor to serve as a reoccurring reminder of the need to complete this task going forward on a regular basis. 3.The ancillary services supervisor will be responsible for correction and monitoring to prevent reoccurrence of this deficiency. 4.Jeremy O□Neil, ancillary services supervisor 5.Corrected by 10/14/2021 1.On October 15, 2021, the ancillary services supervisor ordered the proper signage for the fire sprinkler riser room. 2.The signs arrived and were installed on October 27, 2021, by the ancillary services supervisor. 3.An audit will be completed by the administrator on November 11, 2021, to ensure the facility has proper identifications and labels on the fire sprinkler riser room. 4.Jeremy O□Neil, ancillary services supervisor 5.Corrected by 10/27/2021	
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls	K 362		10/21/21

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K 362	Continued From page 6 constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a corridor wall per NFPA 101 (2012 edition), Life Safety Code, sections 8.4.1, 19.3.6.2.2, 19.3.6.2.3, and 19.3.6.2.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/14/2021 at 11:41 AM, it was revealed by observation that there are two, 6 inch diameter holes located in the physical therapy break room side of the corridor separation wall. An interview with Maintenance Supervisor verified this deficient finding at the time of discovery.	K 362	K362-D 1.On October 18, 2021, the ancillary services supervisor purchased the proper materials to repair the holes in the breakroom. 2.On October 21, 2021, the ancillary services supervisor repaired the holes by installing sheetrock, joint tape, and joint compound. This fix will restrict any potential smoke and allow the sprinkler heads to trigger properly. 3.The administrator will perform an audit on 11/12/2021 to ensure the holes have been properly filled and patched. 4.Jeremy O□Neil, ancillary services	

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K 362	Continued From page 7	K 362	supervisor 5.Corrected by 10/21/2021	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6 , and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/14/2021, at 10:50 AM, during the review of all available fire door test and inspection documentation and an interview with the	K 761	K761-F 1.Fire doors were tested and inspected by the ancillary services supervisor on November 11, 2021, and the results were documented. 2.A document was created and added to duty calendar of the ancillary services supervisor to serve as a reoccurring reminder of the need to complete this task going forward on a regular basis. 3.The ancillary services supervisor will be responsible for correction and monitoring	11/12/21

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K 761	Continued From page 8 Maintenance Supervisor, it was revealed that the facility could not provide any current documentation verifying that the fire door inspection had been completed. An interview with the Maintenance Supervisor verified this finding at the time of discovery.	K 761	to prevent reoccurrence of this deficiency. 4.Jeremy O□Neil, ancillary services supervisor 5.Corrected by 11/12/2021	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/14/2021, at 10:40 AM, during a review of available documentation and an interview with Maintenance Supervisor, it was revealed that the	K 901	K901-F 1.On November 9, 2021, the administrator and ancillary services supervisor reviewed building using Good Samaritan Society template to ensure compliance with a completed utility risk assessment. 3.The ancillary services supervisor will be responsible for correction and monitoring to prevent reoccurrence of this deficiency. 4.Jeremy O□Neil, ancillary services supervisor	11/9/21

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K 901	Continued From page 9 facility could not provide a completed utility risk assessment document at the time of the inspection. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 901	5.Corrected by 11/9/2021	