Electronically Delivered

October 9, 2024

Licensee
Good Samaritan Society - International Falls
2101 Keenan Drive
International Falls, MN 56649

RE: Project Number(s) SL29498015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 5, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

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Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29498	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTER	2101 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29498015-0 On September 3, 2024, through September 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of one employee (unlicensed personnel (ULP)-C) during treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on September 3, 2024, at 1:09 p.m., administrator (A)-G stated the licensee was familiar with current minimum assisted living requirements. On September 4, 2024, at 7:08 a.m., the surveyor	0 510		

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0 510	Continued From page 2 observed ULP-C apply hand sanitizer upon entry to R2's room and took out R2's supplies to complete a blood glucose check. ULP-C used an alcohol wipe to swab R2's right middle finger and without gloved hands, ULP-C poked R2's finger, and squeezed R2's fingertip to obtain a blood sample for the blood glucose test strip. ULP-C applied a cotton swab to R2's fingertip and requested R2 hold the cotton swab to stop the bleeding. Without gloved hands, ULP-C removed the blood glucose test strip from the blood glucose meter, threw away the test strip in the garbage, and ULP-C applied hand sanitizer. On September 4, 2024, at 9:19 a.m., the surveyor observed ULP-C apply hand sanitizer upon entry to R5's room and took out R5's supplies to complete a blood glucose check. ULP-C used an alcohol wipe to swab R5's right pointer finger and without gloved hands, ULP-C poked R2's finger, and squeezed R5's fingertip to obtain a blood sample for the blood glucose test strip. ULP-C applied a cotton swab to R5's fingertip and requested R5 hold the cotton swab to stop the bleeding. Without gloved hands, ULP-C removed the blood glucose test strip from the blood glucose meter, threw away the test strip in the garbage, and ULP-C applied hand sanitizer. On September 4, 2024, at 12:54 p.m., ULP-C stated the best practice for a blood glucose check is to wear gloves due to possible exposure to blood, however, ULP-C stated ULP-C did not put on gloves prior to blood glucose checks for residents. ULP-C further stated ULP-C did not recall blood glucose training that specifically indicated gloves must be worn during a blood glucose check. On September 4, 2024, at 1:12 p.m., clinical	0 510		

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0 510	Continued From page 3 nurse supervisor (CNS)-B stated gloves needed to be donned (put on) prior to a blood glucose check due to possible exposure to blood or bodily fluids. The licensee's Hand Hygiene- Enterprise policy dated March 29, 2022, indicated gloves should be utilized whenever contact with blood, body fluid or other potentially infectious matter is present ... The licensee's Personal Protective Equipment PPE including, Putting on/ Taking off, All Service Lines- Enterprise policy dated December 4, 2023, indicated gloves should be worn any time there is reasonably anticipated occupational exposure (contact with a potentially harmful, physical, chemical, or biological agent). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 4 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on September 3, 2024, at 1:24 p.m., administrator (A)-G stated the licensee was aware of the required contents of the employee record. ULP-C was hired on April 9, 2024, to provide direct assisted living services to residents at the facility. On September 4, 2024, at 7:08 a.m., the surveyor observed ULP-C complete a blood glucose check	0 650		

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0 650	Continued From page 5 for R2. ULP-C's employee record lacked training documentation for blood glucose checks. In addition, ULP-C's record lacked documentation of training and competency evaluation for unplanned time away. On September 4, 2024, at 12:53 p.m., ULP-C stated ULP-C completed a blood glucose training and competency evaluation upon hire with clinical nurse supervisor (CNS)-B. ULP-C further stated ULP-C had completed a training and competency testing evaluation for unplanned time away a "few" weeks ago with CNS-B. On September 4, 2024, at 2:43 p.m., CNS-B stated CNS-B was unable to locate ULP-C's blood glucose training, unplanned time away training, and competency evaluation for unplanned time away in ULP-C's employee record. CNS-B further stated CNS-B trained and completed all competency evaluations for ULP-C, however, CNS-B suggested the documentation must have been misplaced. The licensee's Employee Files and Information-Enterprise policy dated May 22, 2023, indicated employee personnel records included training and qualification records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 6 (a) The facility 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 the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), which included completion of a facility TB risk assessment. In addition, the licensee failed to complete a TB history and symptom screening, along with a two-step TST (tuberculin skin test) or other evidence of a TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 660		

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0 660	Continued From page 7 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 3, 2024, at 1:09 p.m., administrator (A)-G stated the licensee was familiar with current minimum assisted living requirements. TB RISK ASSESSMENT On September 3, 2024, at 3:23 p.m., the surveyor reviewed the undated Appendix B. TB risk assessment worksheet provided by clinical nurse supervisor (CNS)-B. The TB risk assessment worksheet indicated it was an inpatient facility with 54 beds. CNS-B stated the TB risk assessment worksheet provided was for the attached skill nursing facility only and did not include the assisted living. CNS-B further stated CNS-B was not aware a TB risk assessment was required, and CNS-B was just learning the TB requirement process. TB SCREENING ULP-C was hired April 9, 2024, to provide direct care services to residents at the facility. On September 4, 2024, at 7:02 a.m., the surveyor observed ULP-C complete scheduled morning medication administration to R2. ULP-C's employee record lacked evidence of a history and symptoms screening for active TB and completion of a two-step TST or other evidence of TB screening such as a blood test. On September 4, 2024, at 12:52 p.m., ULP-C stated ULP-C had completed a TST in the past at a clinic, however, ULP-C could not recall if ULP-C	0 660		

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0 660	Continued From page 8 completed a two-step TST or single blood draw upon hire at the licensee. On September 4, 2024, at 2:16 p.m., licensed assisted living director in residency (LALDIR)-A stated ULP-C must have "slipped through the cracks" upon hire with new staff in management positions, and a TB screening and a two-step TST were not completed for ULP-C. LALDIR-A further stated the licensee required a TB screen and two step TST upon hire of a new employee. The licensee's TB Prevention and Control Program- Minnesota dated June 5, 2023, indicated state of Minnesota regulations require that the Assisted Living Community (ALC) must establish and maintain a comprehensive TB prevention and control program based on the most current TB infection control guidelines issued by the United States CDC, Division of TB Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR). The licensee's TB Control Plan and Screening for Employees, Senior Living, Rehab/Skilled, Home Health, Child Day- Enterprise policy dated December 7, 2023, indicated new employees will have a baseline TB screening and post-exposure screening according to current CDC recommendations and guidelines and state-specific B Control Program Guidelines. Prior to or upon hire, all employees will receive a baseline TST or single TB blood test. If using a TST, a two-step Mantoux method should be used for testing. The MDH guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB risk assessment should be	0 660		

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0 660	Continued From page 9 completed initially and then for low-risk settings the risk assessment should be updated every other year; each agency should have written TB infection control procedures. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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0 780	Continued From page 10 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code provisions by not providing interconnected smoke alarms, maintaining existing smoke alarms, keeping exits clear of storage and not providing carbon monoxide alarms. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on September 4, 2024, from 10:30 a.m. to 12:15 p.m., with director of maintenance (DM)-E, and consultant (C)-F, the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions:	0 780		

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0 780	Continued From page 11 SMOKE ALARM MAINTENANCE During the tour it was observed the smoke alarm in resident sleeping room 110 had a manufacture date of January 2013. Smoke alarms are required to be maintained and replaced within 10 years of manufacture in accordance with manufactures instructions and current Minnesota Fire Code. INTERCONNECTED SMOKE ALARMS The smoke alarms in resident sleeping room 117 were not interconnected so activation of one alarm activates all alarms within the sleeping unit. Were multiple smoke alarms are required within a sleeping unit all smoke alarms within the sleeping unit are required to be interconnected so activation of one alarm activates all alarms within the sleeping unit according to current Minnesota Fire Code. CARBON MONOXIDE ALARMS It was observed there was not a carbon monoxide alarm installed outside and within 10 feet of the sleeping room in sleeping unit 117. Carbon monoxide alarms are required outside within 10 feet of all sleeping rooms according to current Minnesota Fire Code. STORAGE IN EXIT ROUTE There was storage of cardboard boxes in the marked exit route leading from the corridor to the exterior near the trash room and dumpster outside. Exit routes shall not be used for storage and shall be available for full and immediate use at all times according to current Minnesota Fire Code.	0 780		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 12 During a facility tour on September 4, 2024, at 11:30 a.m., DM-E, and C-F, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (7) day.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29498	A. BUILDING: _____ B. WING _____	09/05/2024

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0 800	Continued From page 13 The findings include: On a facility tour on September 4, 2024, from 10:30 a.m. to 12:15 p.m., with director of maintenance (DM)-E, and consultant (C)-F, the surveyor made the following observations of facility hazard or disrepair: The door closers were removed from fire-resistant rated doors on the trash room near resident sleeping unit 122, housekeeping room near resident sleeping unit 122, housekeeping room near resident sleeping unit 106, and the LALDIR office. Door closers are required to be maintained installed on the fire-resistant rated doors and designed and installed at the time of construction according to current Minnesota Fire Code. During a facility tour on September 4, 2024, at 12:00 p.m., DM-E, and C-F, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 14 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 15 or has potential to affect a large portion or all of the residents). The findings include: TRAINING Record review of the available documentation indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the required resident training was provided annually. During an interview on September 4, 2024, at 10:20 a.m., licensed assisted living director in residence (LALDIR)-A, and consultant (C)-F, stated documentation was not available the required training was provided to residents annually. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation drills were completed January 31, 2024, and June 18, 2024, only. The documentation also indicated the drill on June 18, 2024, included the first and second shift at the same time. Evacuation drills are required to be completed separately for each shift. During an interview on September 4, 2024, at 12:25 p.m., LALDIR-A, and C-F, stated documentation was not available indicating drills were completed as required.	0 810		

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0 810	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=C	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) for one of five employees (director of maintenance (DM)-E). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01290		

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01290	Continued From page 17 The findings include: During the entrance conference on September 3, 2024, at 1:24 p.m., administrator (A)-G stated the licensee was aware of the required contents of the employee record. DM-E was hired on March 1, 2021, and had begun providing assisted living maintenance on August 1, 2021. On September 4, 2024, from 10:30 a.m. through 12:15 p.m., the surveyor observed DM-E on facility tour with the Minnesota Department of Health engineer surveyor. DM-E's employee record contained a cleared background study notice issued by the Minnesota Department of Human Services dated March 1, 2021. The background study was affiliated to the attached skilled nursing facility with the HFID 322. On September 4, 2024, at 1:07 p.m., licensed assisted living director in residency (LALDIR)-A stated DM-E was the current DM for the assisted living and was not listed on the licensee's NETStudy 2.0 roster for HFID 29498. On September 4, 2024, at 3:22 p.m., LALDIR-A stated DM-E background study was run under the skilled nursing facility and was not affiliated with the assisted living. LALDIR-A further stated the human resources department completed all background studies and affiliations of background studies for the assisted living. The licensee's Hiring and Screening- Enterprise policy dated March 24, 2022, indicated Human Resources [sic] will conduct background checks on all new employees and transfers prior to	01290		

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01290	Continued From page 18 beginning employment or transferring to a new position. All offers of employment are contingent upon successful completion of the background check, state-specific background check ... No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=C	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 19 by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for two of two residents (R2, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on September 3, 2024, at 1:09 p.m., administrator (A)-G stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included hypertension (HTN-high blood pressure), diabetes, and muscle weakness. R2's Uniform Assessment Review - MN (Minnesota)- AL (assisted living) were completed July 15, 2024, and July 29, 2024, respectively. On September 4, 2024, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication administration to R2. R4 R4's diagnoses included HTN and osteoarthritis. R4's Uniform Assessment Review - MN-AL were	01620		

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01620	Continued From page 20 completed June 4, 2024, and July 23, 2024, respectively. R2 and R4's Uniform Assessment Review - MN-AL lacked the resident's personal lifestyle preferences including spiritual and cultural preferences required from the uniform assessment tool as identified in Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Subp. 2. On September 5, 2024, at 10:21 a.m., clinical nurse supervisor (CNS)-B stated spiritual and cultural assessments were only addressed when a resident first moved in and not addressed every 90 days. CNS-B further stated all residents assessments contained the same content. The licensee's State-Specific Senior Living Information- Minnesota policy dated October 16, 2023, indicated the assisted living facility shall conduct a nursing assessment, which the nursing assessment components are defined in MN Rule 4659.0105 Uniform Assessment Tool. In addition, ongoing resident reassessment, review and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment	01620		

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01620	Continued From page 21 under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.	01640		

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01640	Continued From page 22 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of two residents (R2). This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on September 3, 2024, at 1:09 p.m., administrator (A)-G stated the licensee was familiar with current minimum assisted living requirements. On September 4, 2024, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication administration to R2. R2's service plan dated August 26, 2024, indicated services included medication administration, blood glucose checks, bathing, light housekeeping, and laundry. R2's service plan lacked a licensee signature or other authentication by the licensee to document	01640		

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01640	Continued From page 23 agreement on the services to be provided. On September 5, 2024, at 10:18 a.m., licensed assisted living director in residency (LALDIR)-A stated R2's service plan was not signed by a representative from the licensee. LALDIR-A further stated LALDIR-A was responsible for going through the service plan with residents and obtaining signatures, however, R2's must have been missed. The licensee's Resident Service Plan, AL (assisted living)- Enterprise policy dated October 24, 2023, indicated the Service Plan [sic] must be printed and then signed and dated by the resident and the ALC (assisted living center) manager or licensed nurse according to state regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

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01760	Continued From page 24 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration documentation included the signature and title of the person who administered medication for one of one resident (R2) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 3, 2024, at 1:13 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R2's diagnoses included hypertension (HTN-high blood pressure), diabetes, and muscle weakness. R2's service plan dated August 26, 2024, indicated services included medication administration, blood glucose checks, bathing, light housekeeping, and laundry. On September 4, 2024, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication administration to R2. ULP-C documented ULP-C's initials on R2's September Medication	01760		

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01760	Continued From page 25 Record (MAR) for medications administered. R2's MAR dated August 2024, and September 2024, respectively, indicated staff administered medications multiple times daily with staff initials, however, R2's MARs lacked the signature and title of the person who administered R2's medications. On September 4, 2024, at 2:45 p.m., CNS-B stated CNS-B could identify each staff members initials on R2's MARs, however, R2's MARs lacked the signature and title of staff who completed medication administration for R2. CNS-B further stated the same information would be lacking on all resident MARs. Licensed assisted living director in residency (LALDIR)-A stated the licensee used to have a staff key (a written list of each staff member's name, title, initials, and signature) to identify initials on the resident's MARs, however, LALDIR-A was not sure why the licensee discontinued using the staff key. The licensee's Medication Administration, AL (assisted living)- Enterprise policy dated April 26, 2024, indicated if a resident required medication administration, this (medication administration) will be completed by licensed nurses or appropriately trained employees who have completed training as outline in the state regulations. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup	01770		

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01770	Continued From page 26 Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 3, 2024, at 1:13 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R4's diagnoses included hypertension (HTN- high blood pressure) and osteoarthritis. R4's Service plan dated August 26, 2024, indicated registered nurse (RN) to set up medications in a pill box (a multicompartment compliance aid for storing scheduled doses of medications) weekly. R4's prescriber orders dated July 20, 2024,	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29498	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTER	2101 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01770	Continued From page 27 included the medications noted below, however, lacked prescriber orders to decrease calcium and vitamin D3 to one time daily, increase acetaminophen from PRN (as needed) to three times daily, increase tramadol from PRN to three times daily, and increase diphenhydramine from PRN to every bedtime. R4's Medication Record (MAR) dated August 2024, and September 2024, respectively, included the following medications were setup by CNS-B: -potassium 20 milliequivalent (mEq) one tablet by mouth twice daily (a.m./p.m.) -calcium and vitamin D3 600 milligrams (mg) 800 units one tablet by mouth daily (a.m.) -gabapentin 300 mg three capsules by mouth three times daily (a.m./lunch/bedtime) -propranolol 60 mg one capsule by mouth daily (a.m.) -acetaminophen 500 mg one tablet by mouth three times daily (a.m./lunch/bedtime) -furosemide 40 mg one tablet by mouth daily (a.m.) -spironolactone 25 mg ½ tablet by mouth daily (a.m.) -prednisone one mg three tablets by mouth daily (a.m.) -tramadol 50 mg one tablet by mouth three times daily (a.m./lunch/bedtime) -multivitamin one tablet by mouth daily (p.m.) -diphenhydramine 25 mg one tablet by mouth daily (bedtime) R4's records lacked documentation for medication setup at the time of setup to include name of the person completing the medication setup. On September 6, 2024, at 10:15 a.m., CNS-B	01770		

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	29498	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTER	2101 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01770	Continued From page 28 stated R4's medication setup lacked CNS-B's name and the licensee no longer used a staff key (a written list of each staff member's name, title, initials, and signature) to identify initials listed on resident MARs. The licensee's Pillbox Set up and Management, AL (assisted living)- Enterprise policy dated June 28, 2024, indicated the nurse will document the date and time the pillbox was filled in the resident's record. In addition, licensed nurses will follow state regulations for any specific documentation components required for the pillbox setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R4) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29498	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTER	2101 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01820	Continued From page 29 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on September 3, 2024, at 1:13 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R4's diagnoses included hypertension (HTN- high blood pressure) and osteoarthritis. R4's Service plan dated August 26, 2024, indicated registered nurse (RN) to set up medications in a pill box (a multicompartment compliance aid for storing scheduled doses of medications) weekly. R4's Medication Record (MAR) dated August 2024, and September 2024, respectively, included the following medications were setup by CNS-B: -calcium and vitamin D3 (supplement) 600 milligrams (mg) 800 units one tablet by mouth daily -acetaminophen (pain reliever) 500 mg one tablet by mouth three times daily -tramadol (pain reliever) 50 mg one tablet by mouth three times daily -diphenhydramine (for insomnia) 25 mg one tablet by mouth daily -lorazepam (antianxiety) 0.5 mg one tablet by mouth twice daily PRN (as needed) R4's prescriber orders dated July 20, 2024, included the following medication orders:	01820		

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	29498	A. BUILDING: _____ B. WING _____	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTER	2101 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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01820	Continued From page 30 -calcium and vitamin D3 600 mg 800 units one tablet by mouth twice daily -acetaminophen 500 mg by mouth every 4 hours PRN -tramadol 50 mg one tablet by mouth three times per day PRN -diphenhydramine 25 mg by mouth at bedtime PRN -lorazepam 0.5 mg by mouth twice daily R4's record lacked prescriber orders to decrease calcium and vitamin D3 to one time daily, increase acetaminophen from PRN to three times daily, increase tramadol from PRN to three times daily, increase diphenhydramine from PRN to every bedtime, and decrease lorazepam from twice daily to PRN. On September 5, 2024, at 10:15 a.m., CNS-B stated the licensee would provide updated prescriber orders for R4 as noted above, however, no additional prescriber orders were provided to the surveyor. The licensee's Medication Administration and Supporting Process- [facility name] policy dated December 5, 2023, indicated each medication administered by staff must be ordered by a medical provider (physician). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01960 SS=F	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960		

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01960	Continued From page 31 assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment administration documentation included the signature and title of the person who administered treatments for one of one resident (R2) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 3, 2024, at 1:22 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services, including blood glucose checks, to residents at the facility. R2's diagnoses included hypertension (HTN-high blood pressure), diabetes, and muscle weakness.	01960		

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01960	Continued From page 32 R2's service plan dated August 26, 2024, indicated services included medication administration, blood glucose checks (a test used to measure the level of glucose (sugar) in the blood), bathing, light housekeeping, and laundry. On September 4, 2024, at 7:08 a.m., the surveyor observed unlicensed personnel (ULP)-C complete a blood glucose check to R2. ULP-C documented ULP-C's initials on R2's September Medication Record (MAR) for blood sugar check. In addition, ULP-C documented the date, time, blood glucose level, and ULP's initials on R2's Blood Sugar Log dated June 22, 2024, through September 4, 2024. R2's MAR dated August 2024, and September 2024, respectively, indicated staff completed a blood sugar check daily at 7:00 a.m. with staff initials, however, R2's MARs lacked the signature and title of the person who completed R2's blood glucose check. In addition, R2's Blood Sugar Log lacked the signature and title of the person who completed R2's blood glucose checks. On September 4, 2024, at 2:45 p.m., CNS-B stated CNS-B could identify each staff members initials on R2's MARs and R2's Blood Sugar Log, however, R2's MARs and Blood Sugar Log lacked the signature and title of staff who completed blood glucose checks for R2. CNS-B further stated the same information would be lacking on all resident's documentation. Licensed assisted living director in residency (LALDIR)-A stated the licensee used to have a staff key (a written list of each staff member's name, title, initials, and signature) to identify initials on the resident's MARs and other resident documentation, however, LALDIR-A was not sure why the licensee discontinued using the staff key.	01960		

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01960	Continued From page 33 The licensee's Treatment and Therapy Management Services- Minnesota policy dated March 18, 2024, indicated treatment documentation would include the signature and title of the person who administered the treatment or therapy. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication setup by unlicensed personnel (ULP) for one of one resident (R3). In addition, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	02320		

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02320	Continued From page 34 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on September 3, 2024, at 1:13 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. MEDICATION SETUP R3's diagnoses included diabetes, insomnia (difficulty sleeping), and unspecified personality disorder. R3's service plan dated July 30, 2024, indicated R3's services included medication administration. R3's Medication Record (MAR) dated September 2024, indicated ULP-H administered R3's scheduled 6:00 a.m. morning medications. On September 4, 2024, at 6:00 a.m., the surveyor observed a non-labeled paper cup, with multiple medications, sitting on the counter in the staff office. At 6:08 a.m., ULP-H stated the medications in the non-labeled paper cup were for R3, and ULP-H was waiting for R3 to arrive at the dining room for scheduled morning medication administration. At 6:22 a.m., ULP-C stated ULP-H verbalized to ULP-C, the medications in the non-labeled paper cup in the office were R3's scheduled morning medications. At 6:31 a.m., the surveyor observed ULP-C bring the non-labeled paper cup with medications from the staff office to R3 in the dining room, and ULP-C administered the medications to R3.	02320		

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02320	Continued From page 35 Immediately following the observation, ULP-C brought R3 to the spa room for a bath, and the surveyor did not observe ULP-C document the administration of R3's medications. On September 4, 2024, at 7:00 a.m., ULP-C stated ULP-H had documented the administration of R3's scheduled morning medications. ULP-C further stated ULP-C would know "for the most part" if any medications were missing in the paper cup and R3 would also be able to verbalize if any scheduled morning medications were not included in the non-labeled paper cup. On September 4, 2024, at 1:09 p.m., CNS-B stated ULPs were never supposed to setup medications for another ULP to administer. CNS-B stated the medications in the non-labeled paper cup setup by ULP-H, should have been disposed of per policy, and new medications should have been administered to R3 by ULP-C. CNS-B further stated the ULP that administered the medications to R3 should be the same ULP that documented on R3's MAR the medications were administered. According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. The licensee's Pillbox Setup and Management, AL (assisted living)- Enterprise policy dated June	02320		

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02320	Continued From page 36 28, 2024, indicated only a licensed nurse may setup and manage a pill box (a multicompartment compliance aid for storing scheduled doses of medications) and instruct the resident in the proper use of the pillbox. The licensee's Medication Administration, AL-Enterprise policy dated April 26, 2024, indicated if a resident required medication administration, this (medication administration) will be completed by licensed nurses or appropriately trained employees who have completed training as outline in the state regulations. MEDICATION ADMINISTRATION On September 4, 2024, at 9:22 a.m., the surveyor observed ULP-C provide scheduled morning medication administration to R5, which included administration of R5's insulin pens. Without cleaning the hub (tip of insulin pen the needle is applied to) of the insulin pen, ULP-C applied the needle to R5's Lispro 100 units/milliliter (mL) insulin pen, dialed the insulin pen to two units and discarded, dialed the insulin pen to 28 units, handed the insulin pen to R5, and R5 self-administered the insulin. Without cleaning the hub of the insulin pen, ULP-C applied the needle to R5's Toujeo 300 units/mL insulin pen, dialed the insulin pen to two units and discarded, dialed the insulin pen to 80 units, handed the insulin pen to R5, and R5 self-administered the insulin. The surveyor did not observe ULP-C cleanse the insulin pen hub before or after attaching the needle. On September 4, 2024, at 12:57 p.m., ULP-C stated ULP-C did not clean either of R5's insulin pen hubs prior to applying the needle to the insulin pen. ULP-C further stated ULP-C did not recall being trained on cleaning the insulin pen	02320		

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02320	Continued From page 37 hub prior to the application of the needle. On September 4, 2024, at 2:43 p.m., CNS-B stated ULPs were trained to "scrub the hub" with an alcohol wipe to each insulin pen before the needle is placed on the insulin pen. The manufacturer instructions for Lispro dated February 2020, indicated to wipe the rubber seal (hub) with an alcohol swab prior to putting on the needle. The manufacturer instructions for Toujeo dated February 2015, indicated to wipe the rubber seal with an alcohol swab prior to attaching the needle. The licensee's Insulin Preparation and Administration, AL (assisted living)- Enterprise policy dated June 28, 2024, indicated to wipe the tip of the pen (insulin pen) where the needle will attach with an alcohol swab or cotton ball moistened with alcohol prior to screwing on the needle to the insulin pen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Type: Full
Date: *09/04/24*
Time: 13:19:42
Report: 1019241100

Food and Beverage Establishment Inspection Report

Location:

Good Samaritan Society - Inter
2101 Keenan Drive
International Falls, MN56649
Koochiching County, 36

Establishment Info:

ID #: 0037725
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182831300
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at 161 F Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 F Degrees Fahrenheit - Location: 2 DOOR REACH IN COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

INSPECTION INCLUDED AS PART OF THE HEALTH REGULATION DIVISION INSPECTION.
DISCUSSION:
MENU,
FOOD BEING BROUGHT OVER FROM GOOD SAM NURSING KITCHEN,
PROCEDURE FOR TEMPING FOOD PRIOR-POST TRANSIT,
LIMITED FOOD BEING PREPPED/COOKED IN KITCHEN,
USE OF PASTEURIZED EGGS AND JUICE PRODUCTS,

Type: Full
Date: *09/04/24*
Time: 13:19:42
Report: 1019241100
Good Samaritan Society - Inter

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1019241100 of 09/04/24.

Certified Food Protection Manager: KAREN L. SALO

Certification Number: FM 97837 Expires: 03/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
KAREN L. SALO
CFPM

Signed: _____
Jared Morrill
Sanitarian
Bemidji
218 308-2128