Electronically Delivered

October 13, 2021

Administrator
Good Samaritan Society-Heritag
2122 River Road Northwest
East Grand Forks, MN 56721

RE: Project Number(s) SL24554015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 15, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. 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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 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 the Department of Health within 15 calendar days.

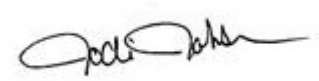
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24554	A. BUILDING: _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY-HERITAG	2122 RIVER ROAD NW EAST GRAND FORKS, MN 56721

(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
0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING 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: Project #: SL24554015 On September 13, 2021 through September 15, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 82 residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 surveyors' 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.	
0 480 SS=F	144G.41 Subdivision 1 Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code chapter 4626. This had the potential to affect all 82 residents residing at the facility. 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 is 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	0 480		

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0 480	Continued From page 2 portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 13, 2021, for the specific Minnesota Food Code deficiencies.. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the facility posted required information about the facility's grievance procedure to contain all required content. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 550		

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0 550	Continued From page 3 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 is 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: The licensee lacked a posting of the grievance procedure, along with the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On September 13, 2021, during the facility tour at approximately 11:00 a.m., the surveyors observed three units' common areas and noted the lack of the required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC. During the tour, Licensed Assisted Living Director (LALD)-A showed the surveyors the posted grievance policy, which was hidden behind the facility's license posting. The posted grievance policy did not contain the following: the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman	0 550		

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0 550	Continued From page 4 for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). LALD-A confirmed the required content noted above had not been posted as required. The licensee's policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This	0 640		

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0 640	Continued From page 5 had the potential to affect all current 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 is 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: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. In addition, there was no evidence of the contact information or reporting number for the Minnesota Adult Abuse Reporting Center (MAARC). On September 13, 2021, during the facility tour at approximately 11:00 a.m., the surveyors observed three units' common areas; there was no required posting of the 911 emergency number and the reporting number for MAARC. On September 13, 2021, at approximately 12:45 p.m., Licensed Assisted Living Director (LALD)-A confirmed the 911 emergency number and the reporting number for MAARC were not posted in common areas. LALD-A stated due to many residents having telephones in their apartments and/or mobile telephones, she did not think the posting was needed; however, the information would be provided if a resident wanted the contact information. The licensee's policy was requested, but not	0 640		

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0 640	Continued From page 6 provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 7 Based on observation, interview and record review, the licensee failed to ensure it completed a written emergency disaster plan with all required content outlined in Appendix Z. This had the potential to affect all current 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). The findings include: On September 13, 2021, at approximately 1:10 p.m. a request was made to view the licensee's emergency preparedness plan, which was later reviewed by the surveyor. The plan contained a flip chart of various emergency situations, including how staff should respond in the event of a hurricane and earthquake. The facility's policies contained direction on making an emergency plan, and the policies listed various emergency situations (such as heat, several weather emergencies, emergency evacuations, plan activations); however, the procedures spelled out in the plan were generic, lacking specificity to the facility. The facility's plan lacked the following required content: -all hazards based emergency preparedness program with a risk assessment considering all hazards that may impact all or a portion of the facility; -an assessment of the at risk population's needs;	0 680		

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0 680	Continued From page 8 -a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations; -policies and procedures that are stored in a central place; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies and procedures, based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents and how the facility will provide care under an 1135 waiver declared by the Secretary; -a plan for sheltering in place when not able to evacuate; -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents. On September 15, 2021, at 9:05 a.m., Licensed Assisted Living Director (LALD)-A stated the facility completed a hazard vulnerability risk assessment; however, it was on the computer	0 680		

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0 680	Continued From page 9 system and not readily accessible. LALD-A stated the flip chart staff would utilize in the event of an emergency was one that the national campus had created and was not individualized based on the facility's risk assessment. LALD-A stated she was not aware of all the requirements outlined in Appendix Z, and the facility had not implemented all the required components of Appendix Z. The licensee's "Emergency Management Plan" policy dated February 26, 2021, indicated all Good Samaritan Society policy and procedure required all locations have a comprehensive emergency and disaster management plan in place for all service lines provided at the location. The policy directed that the location's plan needed to be made specific to all disasters that could potentially affect the location. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 910 SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910		

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0 910	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for four of four residents (R3, R4, R5, R6) with records reviewed. 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). The findings include: R3, R4, R5, and R6's contracts lacked all the required content. R3 R3's service plan dated August 1, 2021, indicated R3 received services including medication administration, dressing and showering assistance, oxygen monitoring, and diabetic management and monitoring, including blood glucose checks. On September 14, 2021, at 8:00 a.m. unlicensed personnel (ULP)-F was observed administering R3's scheduled morning medications and checking R3's blood glucose. R3's contract dated July 7, 2021, lacked the following required content: - the licensee of the facility. R4 R4's service plan dated August 12, 2021, indicated R4 received services including medication administration and assistance with showering, laundry, meal and activity reminders. On September 14, 2021, at 8:15 a.m. ULP-F was	0 910		

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0 910	Continued From page 11 observed administering R4's scheduled morning medications. R4's contract dated August 11, 2021, lacked the following required content: - the licensee of the facility. R5 R5's service plan dated August 1, 2021, indicated R5 received services including medication administration, shower assistance, and incontinence management. On September 14, 2021, at 9:35 a.m. ULP-E was observed administering scheduled morning medications to R5. R5's contract dated July 13, 2021, lacked the following required content: - the licensee of the facility. R6 R6's service plan dated August 1, 2021, indicated R6 received services including medication administration and assistance with dressing, grooming, and showering. On September 14, 2021, at 9:20 a.m. ULP-E was observed administering scheduled morning medications to R6. R6's contract dated July 7, 2021, lacked the following required content: - the licensee of the facility. On September 15, 2021, at approximately 9:20 a.m., Licensed Assisted Living Director (LALD)-A confirmed the licensee used the same contract for all residents, and the organization's legal department was responsible for drafting the contract language. The licensee's Resident Medical Record Documentation Documentation policy dated September 8, 2021, indicated the licensee would comply with state-specific regulations. The policy did not include information specific to the contract. No additional information was provided.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24554	A. BUILDING: _____ B. WING _____	09/15/2021

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0 910	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=F	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R3, R4, R5, R6) with records reviewed. This practice resulted in a level two violation (a	0 920		

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0 920	Continued From page 13 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: R3, R4, R5, and R6's contracts lacked all of the required content. R3 R3's service plan dated August 1, 2021, indicated R3 received services including medication administration, dressing and showering assistance, oxygen monitoring, and diabetic management and monitoring, including blood glucose checks. R3's contract dated July 7, 2021, lacked the following required content: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and - disclosure of the facility's ability to provide specialized diets. On September 14, 2021, at 8:00 a.m. unlicensed personnel (ULP-F) was observed administering R3's scheduled morning medications and checking R3's blood glucose. R4 R4's service plan dated August 12, 2021,	0 920		

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0 920	Continued From page 14 indicated the resident received services including medication administration, assistance with showering, laundry, meal and activity reminders. R4's contract dated August 11, 2021, lacked the following required content: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and - disclosure of the facility's ability to provide specialized diets. On September 14, 2021, at 8:15 a.m. ULP-F was observed administering R4's scheduled morning medications. R5 R5's service plan dated August 1, 2021, indicated R5 received services including medication administration, shower assistance, and incontinence management. R5's contract dated July 13, 2021, lacked the following required content: -a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and -disclosure of the facility's ability to provide specialized diets. On September 14, 2021, at 9:35 a.m. ULP-E was observed administering scheduled morning medications to R5.	0 920		

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0 920	Continued From page 15 R6 R6's service plan dated August 1, 2021, indicated R6 received services including medication administration and assistance with dressing, grooming, and showering. R6's contract dated July 7, 2021, lacked the following required content: - a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; and - disclosure of the facility's ability to provide specialized diets. On September 14, 2021, at 9:20 a.m. ULP-E was observed administering scheduled morning medications to R6. On September 15, 2021, at approximately 9:20 a.m. licensed assisted living director (LALD)-A confirmed the licensee used the same contract for all residents, and the organization's legal department was responsible for drafting the contract language. The licensee's Resident Medical Record Documentation Documentation policy dated September 8, 2021, indicated the licensee would comply with state-specific regulations. The policy did not include information specific to the contract. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		

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01620	Continued From page 16	01620		
01620 SS=E	144G.70 Subd. 2 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 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a timely comprehensive reassessment using the uniform assessment tool for four of four residents (R4, R3, R5, R6) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 17	01620		

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:
R4 - 14 DAY ASSESSMENT
R4 was admitted for services on August 12, 2021.
R4's diagnoses included, but were not limited to, hypertension (high blood pressure), osteoarthritis, emphysema (diminished ability of the lungs to dilate causing shortness of breath) and chronic constipation.
R4's service plan dated August 12, 2021, indicated R4 received services including medication administration and assistance with showering, laundry, meal and activity reminders.
R4's record included a Monitoring and Reassessment dated August 25, 2021, which indicated R4 required assistance with bathing, medication administration and laundry; however, the assessment lacked the required content for the Uniform Assessment Tool.
On September 14, 2021, at 8:15 a.m., unlicensed personnel (ULP)-F was observed administering R4's scheduled morning medications.
On September 14, 2021, at 10:35 a.m., registered nurse (RN)-B confirmed the Uniform Assessment Tool was not completed for R4's 14 day assessment.
R3 - 90 DAY ASSESSMENT
R3's record lacked 90 day assessments as required.
R3's diagnoses included, but were not limited to, hypertension, chronic kidney disease, congestive heart failure (CHF) and diabetes.
R3's record included a Monitoring and

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01620	Continued From page 18 Reassessment for a 90-day visit dated December 2, 2020. This assessment indicated R3 required assistance with dressing, bathing, laundry and medication administration; however, R3's record lacked any other additional assessments. R3's service plan dated August 1, 2021, indicated R3 received services including medication administration, dressing and showering assistance, oxygen monitoring, and diabetic management and monitoring, including blood glucose checks. On September 14, 2021, at 8:00 a.m. ULP-F was observed administering R3's scheduled morning medications and checking R3's blood glucose. On September 14, 2021, at approximately 10:45 a.m., RN-B confirmed R3's record lacked any other additional assessments. RN-B confirmed the licensee had continued issues maintaining all assessments in the resident's records as items were not filed promptly. RN-B was certain the assessments had been completed, although RN-B was unable to produce evidence of the completed assessments. RN-B stated she had a 90 day assessment flowsheet she used to track when assessments were due. R5 R5's diagnoses included, but were not limited to, hypertension (high blood pressure), hyperlipidemia (high cholesterol), hypothyroidism, and chronic obstructive pulmonary disease (COPD). R5's service plan, dated August 1, 2021, indicated R5 received services including medication administration, shower assistance, and incontinence management. R5's record included a Monitoring and Reassessment for a 90 day visit dated August 2, 2021. The reassessment did not include all the required content for the Uniform Assessment Tool.	01620		

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01620	Continued From page 19 On September 14, 2021, at 9:35 a.m., ULP-E was observed administering scheduled morning medications to R5. R6 R6's diagnoses included, but were not limited to, congestive heart failure (CHF), cardiomegaly (enlarged heart), hypertension (high blood pressure), and obstructive sleep apnea. R6's service plan dated August 1, 2021, indicated R6 received services including medication administration and assistance with dressing, grooming, and showering assistance. R6's record included a Monitoring and Reassessment for a 90 day visit dated August 3, 2021. The reassessment did not include all the required content for the Uniform Assessment Tool. On September 14, 2021, at 9:20 a.m. ULP-E was observed administering scheduled morning medications to R6. On September 14, 2021, at approximately 10:45 a.m. RN-B confirmed R5 and R6's 90 day assessments did not include all the required content. The licensee's Resident Medical Record Documentation Requirements policy dated September 8, 2021, noted the licensee would have policies and procedures in compliance with state-specific regulations; however, the licensee's policy lacked the required content for the Uniform Assessment Tool to be used for all assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and	01710		

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01710	Continued From page 20 reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed face-to-face medication management re-assessments at least annually for three of four residents (R5, R6, R3) with records reviewed. 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 13, 2021, at approximately 10:45 a.m., RN-B confirmed the licensee provided medication management services for residents of the facility. R5 R5's diagnoses included, but were not limited to, hypertension (high blood pressure), hyperlipidemia (high cholesterol), hypothyroidism, and chronic obstructive pulmonary disease (COPD). R5's Medication Management Assessment dated August 26, 2020, and R5's service plan dated August 1, 2021, indicated R5 received medication	01710		

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01710	Continued From page 21 management services, including daily medication administration. R5's prescriber orders dated January 14, 2021, included, but were not limited to, four supplements, one antidepressant, one analgesic, one inhaler for COPD, one eye drop, one blood thinner, one acid reflux reducer, one blood pressure lowering medication, and one thyroid medication. On September 14, 2021, at 9:35 a.m., unlicensed personnel (ULP)-E was observed administering scheduled morning medications to R5. R5's record lacked evidence of any additional medication management services assessments were completed to include a review of all the medications R5 was known to be taking to include: indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On September 14, 2021 at approximately 10:45 a.m., RN-B confirmed R5 did not have an up-to-date medication management assessment, and it was 'overdue.' R6 R6's diagnoses included, but were not limited to, congestive heart failure (CHF), cardiomegaly (enlarged heart), hypertension (high blood pressure), and obstructive sleep apnea. R6's Medication Management Assessment dated August 26, 2020, and R6's service plan dated August 1, 2021, indicated R6 received medication management services, including daily medication administration.	01710		

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01710	Continued From page 22	01710		

R6's prescriber orders dated May 11, 2021, included, but were not limited to, one blood thinner, three supplements, one blood pressure medication, one diuretic, and one eye drop.

On September 14, 2021, at 9:20 a.m., ULP-E was observed administering scheduled morning medications to R5.

R6's record lacked evidence of any additional medication management services assessments were completed to include a review of all the medications R6 was know to be taking to include: indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

On September 14, 2021, at approximately 10:45 a.m., RN-B confirmed R6 did not have an up-to-date medication management assessment, and it was 'overdue.'

R3
R3's diagnoses included, but were not limited to, hypertension (high blood pressure), congestive heart disease, chronic kidney disease, and diabetes.

R3's Medication Management Assessment and service plan, both dated July 1, 2020, indicated R3 received medication management services, including daily medication administration.

R3's prescriber orders dated May 4, 2021, included, but were not limited to, one blood thinner, five supplements, one cholesterol reducer, one antihistamine, one inhaler for chronic obstructive pulmonary disease, two laxatives, one thyroid medicine, one blood pressure medication, three insulins for diabetes,

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01710	Continued From page 23 and two diuretics. On September 14, 2021, at 8:00 a.m., ULP-F was observed administering scheduled morning medications to R3. R3's record lacked evidence any additional medication management services assessments were completed to include a review of all the medications R3 was know to be taking to include: indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On September 14, 2021, at approximately 10:45 a.m., RN-B confirmed R3's record lacked all of R3's assessments, and stated it was an on-going issue with filing, although she was confident it had been completed. RN-B stated she had a 90-day assessment flowsheet she used to track when all types of assessments were due. The licensee's Resident Medical Record Documentation Requirements policy dated September 8, 2021, indicated medical record documentation would be in compliance with state-specific regulations; however, the policy lacked requirement of at least annual medication management services reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 24 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 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 as needed (PRN) medications had documentation of effectiveness after administration for one of four residents (R4) with records reviewed. 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 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: R4's Medication Management Assessment and service plan, both dated August 12, 2021, indicated R4 received medication management services daily. R4's prescriber orders dated August 13, 2021, included, but were not limited to, the following: -acetaminophen 650 milligrams (mg) by mouth every four hours PRN for pain; and	01760		

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GOOD SAMARITAN SOCIETY-HERITAG	2122 RIVER ROAD NW EAST GRAND FORKS, MN 56721

(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
01760	Continued From page 25 -milk of magnesia 400 mg/5 milliliters (ml) suspension, 30 ml by mouth daily PRN for constipation. R4's medication administration records (MAR) from August 13, 2021, to August 31, 2021, indicated the following: -acetaminophen 650 mg by mouth PRN was administered six times; four of the six administrations lacked documentation of effectiveness. On September 14, 2021, at 10:35 a.m., registered nurse (RN)-B noted all PRN medications should have documentation of effectiveness for every dose administered. The licensee's Medication Administration and Supporting Process - East Grand Forks AL, Heritage Grove policy dated January 22, 2021, lacked a process for PRN medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Full
Date: *09/13/21*
Time: 11:00:00
Report: 1008211025

Food and Beverage Establishment Inspection Report

Location:
Good Samaritan Society Heritag
2122 River Road NW
East Grand Forks, MN56721
Polk County, 60

Establishment Info:
ID #: N003210
Risk: High
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:
The Evangelical Lutheran Good

Phone #:
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.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.116 ** Priority 2 **

MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.

PROVIDE READILY ACCESSIBLE TEST STRIPS FOR THE QUATERNARY SANITIZING SOLUTION USED WITHIN THE KITCHENS. THERE WERE NO TEST STRIPS READILY ACCESSIBLE IN THE PINES KITCHEN.

Comply By: 09/16/21

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE REFRIGERATOR IN THE OAKS KITCHEN IS A DOMESTIC UNIT AND THE COUNTERTOP GRIDDLES WITHIN THE KITCHENS ARE DOMESTIC UNITS. GRIDDLES AND REFRIGERATORS NEED TO BE ANSI CERTIFIED PIECES OF EQUIPMENT. REPLACE THESE UNITS WITH ANSI CERTIFIED PIECES.

Comply By: 11/16/21

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

A THERMOMETER WAS PROVIDED IN THE WALK-IN COOLER IN THE MAPLES KITCHEN, HOWEVER IT WAS NOT OPERATIONAL. PROVIDE AN OPERATIONAL THERMOMETER IN THE WALK-IN COOLER IN THE MAPLES KITCHEN.

Comply By: 09/16/21

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

THE SIDE WALL WHERE THE RANGE WITH BURNERS IS LOCATED NEEDS TO BE STAINLESS STEEL PANELS LIKE THE PANELS BEHIND THE COOKING EQUIPMENT. THE FRP IS BROWNING AND WARPING DUE TO THE HEAT.

Comply By: 09/27/21

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish machine - Maples Kitchen
Violation Issued: No

Hot Water: = at 177 Degrees Fahrenheit
Location: Dish machine - Pines Kitchen
Violation Issued: No

Hot Water: = at 174 Degrees Fahrenheit
Location: Dish machine - Oaks Kitchen
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sanitizer - Pines Kitchen
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Steam Table
Temperature: 206 Degrees Fahrenheit - Location: Brat - Maples Kitchen
Violation Issued: No

Process/Item: Steam Table
Temperature: 202 Degrees Fahrenheit - Location: Sour Kraut - Maples Kitchen
Violation Issued: No

Process/Item: Steam Table
Temperature: 176 Degrees Fahrenheit - Location: German Potatoes - Maples Kitchen
Violation Issued: No

Process/Item: Steam Table
Temperature: 201 Degrees Fahrenheit - Location: Soup - Maples Kitchen
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 41 Degrees Fahrenheit - Location: Cake - Maples Kitchen
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Steam Table
Temperature: 165 Degrees Fahrenheit - Location: Sour Kraut - Pines Kitchen
Violation Issued: No

Process/Item: Steam Table
Temperature: 180 Degrees Fahrenheit - Location: Brat - Pines Kitchen
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: Ice box cake - Pines Kitchen
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Cream - Oaks Kitchen
Violation Issued: No

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

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

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 Minnesota Department of Health inspection report number 1008211025 of 09/13/21.

Certified Food Protection Manager: Tiffany M Kuznia

Certification Number: FM99679 Expires: 04/22/22

Signed: emailed To HRD
Establishment Representative

Signed: Inspector ID# 1088

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us

Report #: 1008211025

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
PO Box 64495
St Paul, Minnesota

No. of RF/PHI Categories Out	0	**Date**	09/13/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:00:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Good Samaritan Society Heritag	**Address** 2122 River Road NW	**City/State** East Grand Forks, MN	**Zip Code** 56721	**Telephone**
License/Permit # N003210	**Permit Holder** The Evangelical Lutheran Good	**Purpose of Inspection** Full	**Est Type**	**Risk Category** H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) emailed To HRD **Date:** 09/14/21

Inspector (Signature) Inspector ID# 1008