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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CXMF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00058

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 12/05/2016
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/03/2017
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/26/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

On November 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 11, 2016 and a Federal Monitoring Survey (FMS) completed on September 16, 2016. We presumed, based on your plan of correction, that the facility had corrected these deficiencies as of October 24, 2016. Based on our PCR, we have determined that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 11, 2016 and an FMS completed on September 16, 2016, effective October 24, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in the CMS letter of September 30, 2016. The CMS Region V Office concurred and has authorized this Department to notify the facility of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 11, 2016, be rescinded. (42 CFR 488.417 (b))

In the CMS letter of September 30, 2016, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 11, 2016, due to denial of payment for new admissions. Since the facility attained substantial compliance on October 24, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b forms for the health, life safety code and FMS visits.

Effective October 24, 2016 the facility is certified for 50 skilled nursing facilty beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245476

January 3, 2017

Ms. Karen Prososki, Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue, PO Box 29
Pine River, Minnesota 56474

Dear Ms. Prososki:

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

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

Effective October 24, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Electronically delivered
December 5, 2016

Ms. Karen Prososki, Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue, PO Box 29
Pine River, Minnesota 56474

RE: Project Number S5476027, S5476029

Dear Ms. Prososki:

On August 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 11, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On August 10, 2016, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 30, 2016, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 11, 2016 (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of September 30, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 11, 2016.

On November 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 11, 2016 and a Federal Monitoring Survey

(FMS) completed on September 16, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 24, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 11, 2016 and an FMS completed on September 16, 2016, effective October 24, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in the CMS letter of September 30, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 11, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 11, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 11, 23016, is to be rescinded.

In the CMS letter of September 30, 2016, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 11, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 24, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245476 Y1	A. Building B. Wing Y2	11/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0248	Correction	ID Prefix F0282	Correction	ID Prefix F0315	Correction
Reg. # 483.15(f)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(d)	Completed
LSC	09/13/2016	LSC	09/13/2016	LSC	09/13/2016
ID Prefix F0371	Correction	ID Prefix F0456	Correction	ID Prefix	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.70(c)(2)	Completed	Reg. #	Completed
LSC	09/13/2016	LSC	09/13/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	LB/mm	12/05/2016	34985	11/22/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/11/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245476 Y1	A. Building 01 - 1985 BUILDING AND ADDITIONS B. Wing Y2	9/13/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	08/19/2016	LSC K0027	08/30/2016	LSC K0029	08/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0051	09/12/2016	LSC K0062	08/10/2016	LSC K0075	08/10/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	12/05/2016	36536	09/13/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/10/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 5, 2016

Ms. Karen Prososki, Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue, PO Box 29
Pine River, Minnesota 56474

Re: Reinspection Results - Project Number S5476027

Dear Ms.. Prososki:

On November 22, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 11, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00058 Y1	A. Building B. Wing Y2	11/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20910	Correction	ID Prefix 21015	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0525 Subp. 5 A.B	Completed	Reg. # MN Rule 4658.0610 Subp. 7	Completed
LSC	09/13/2016	LSC	09/13/2016	LSC	09/13/2016
ID Prefix 21435	Correction	ID Prefix 21695	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.0900 Subp. 1	Completed	Reg. # MN Rule 4658.1415 Subp. 4	Completed	Reg. #	Completed
LSC	09/13/2016	LSC	09/13/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	LB/mm	12/05/2016	34985	11/22/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/11/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245476

September 30, 2016
By Certified Mail and Facsimile

Ms. Karen Prososki, Administrator
Good Samaritan Society – Pine River
518 Jefferson Avenue
Pine River, MN 56474

Dear Ms. Prososki:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS
Cycle Start Date: August 11, 2016

STATE SURVEY RESULTS
On August 10, 2106, a Life Safety Code (LSC) survey and on August 11, 2016, a health survey were completed at Good Samaritan Society – Pine River by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance with the most serious deficiencies at Scope and Severity (S/S) level F, cited as follows:

- F371 -- S/S: F -- 483.35(i) -- Food Procure, Store/prepare/serve – Sanitary
- K57 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The MDH advised you of the deficiencies that led to this determination and provided you with a copy of the survey reports (CMS-2567).

FEDERAL MONITORING SURVEY
On September 16, 2016, a survey team representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious cited as follows

- F371 -- S/S: F -- 483.35(i) -- Food Procure, Store/prepare/serve – Sanitary
- F456 -- S/S: X -- 483.70(c)(2) -- Essential Equipment, Safe Operating Condition

The findings from the FMS will be posted on the ePOC system. Enclosed is a list of the “resident identifiers” used in writing the Statement of Deficiencies. The “resident identifiers” will enable

you to identify any specific residents referred to in the CMS-2567.

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

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

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

INFORMAL DISPUTE RESOLUTION
The MDH offered you an opportunity for Informal Dispute Resolution (IDR) following its survey visits. A request for IDR does not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR §488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Stephen Pelinski at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care
- Remedies imposed
- Alleged failure of the surveyor to comply with a requirement of the survey process
- Alleged inconsistency of the surveyor in citing deficiencies among facilities
- Alleged inadequacy or inaccuracy of the IDR process

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your ePOC. You must provide an acceptable ePOC for <u>all</u> cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR.

Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

The facility must request independent IDR in writing within 10 days of receipt of CMS's offer. However, a facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the civil money penalty.

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings we are imposing the following remedy:

- Mandatory denial of payment for new admissions effective November 11, 2016

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR §488 Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Mandatory denial of payment for all new Medicare admissions is imposed effective November 11, 2016, if your facility does not achieve compliance within the required three months. This action is mandated by the Act at §§ 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR §488.417(b). We will notify Noridian Administrative Services that the denial of payment for all new Medicare admissions is effective on November 11, 2016. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective November 11, 2016.

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

TERMINATION PROVISION
If your facility has not attained substantial compliance by February 11, 2017, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §1819(h) and §1919(h) and Federal regulations at 42 CFR §488.456 and §489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR §489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) and Nurse Aide Competency Evaluation Programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,314; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 11, 2016, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society – Pine River will be prohibited from offering or conducting a NATCEP for two years from November 11, 2016. You will receive further information regarding this from the MDH. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the MDH and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS
This formal notice imposed the following remedy:

- Mandatory denial of payment for new admissions effective November 11, 2016

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR § 498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice. It is important that you send a copy of your request to our Chicago office to the attention of Tamika J. Brown.

CONTACT INFORMATION
If you have any questions please contact Tamika J. Brown, Principal Program Representative at (312) 353-1502. Information may also be faxed to (443) 380-6614.

Sincerely,

Jean Ay, Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A health comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on September 16, 2016 following Minnesota Department of Health (MDH) survey on August 11, 2016. Survey Dates: September 12, 2016 to September 16, 2016 Survey Census: 45 Medicare: 2 Medicaid: 29 Other: 14 Total: 45 Stage 1 Sample: 30 Stage 2 Sample: 35	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		10/24/16

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

Electronically Signed | 10/07/2016

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F 225	Continued From page 1 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to immediately report allegations of resident abuse to the Administrator and the State Agency and thoroughly investigate and report final results to the State Agency within 5 working days of the incident for three (R80, R9, and R81) of 30 residents reviewed for abuse. Findings include: 1. The 5/26/16 admission Minimum Data Set (MDS - a federally required comprehensive assessment) recorded R80's Brief Interview for Mental Status (BIMS) score 15, which indicated the resident was cognitively intact.	F 225	Preparation and execution of this response and plan of correction does not constitute an admission or agreement or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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F 225	Continued From page 2 During an interview on 9/13/16 at 11:17am, R80 revealed that a Nurse Aide (NA) yelled at her after requesting care for an incontinence episode. R80 stated that another NA witnessed the incident and reported it to administration. R80 stated that the NA continues to provide care to her. Record review of the "Suggestion or Concern" form dated 7/9/16, revealed that R80 reported to Registered Nurse (RN3) that NA9 told R80 to "get up and use [bathroom] herself." R80 reported that NA9 was "rude" and "mocking" the resident the whole time and the resident was "afraid to ask for help now." The form recorded NA9 stated that R80 was trying to "argue." NA9 did not feel she was being rude to R80. The form revealed that NA7 was also in the room and reported to RN3 that NA9 was argumentative toward R80. The facility did not have any additional information related to the concern. During an interview on 9/15/16 at 1:20pm, R80 stated she was "afraid, leery, and did not trust" NA9 after NA9 yelled at her and stated "that really upset me, I had to go out to the desk and talk to [NA7] just to calm down." R80 stated that she was still "afraid" of NA9 because she did not want to be yelled at like that again. During an interview on 9/15/16 at 1:55pm, RN3 stated that if there was an allegation of abuse, then staff interviewed everyone present, assessed the resident, and filled out the Internal "Suggestion or Concerns" form. RN3 stated that any suspected abuse would be reportable to the State Agency (SA), additional residents and staff would be interviewed and the alleged perpetrator would be removed from resident care areas until the investigation was completed. RN3 stated she	F 225	F225- Investigate/ Report Allegations/ Individuals 1. Incidents involving Residents R80, R81 and R9 were reported to the Administrator and the State Agency on the following dates: a. R9: Reported to Administrator and State Agency on 10/4/2016; investigation was completed and final results were submitted on 10/5/2016. b. R80: Reported to Administrator and State Agency on 9/16/2016; investigation was completed and final results were submitted on 9/21/2016. c. R81: Reported to Administrator and State Agency on 10/4/2016; investigation was completed and final results were submitted on 10/4/2016. 2. This deficiency has the potential to affect all residents. 3. On 10/3/2016, Administrator provided re-education to RN Unit Managers, Social Services RN, Director of Nursing, Rehab RN, MDS RN, Staff Development/ QAPI RN by Administrator on immediately reporting allegations of resident abuse to the Administrator and the State Agency and thoroughly investigating and reporting final results to the State Agency within 5 working days of the incident. Administrator re-educated all staff	

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F 225	Continued From page 3 did not interview any other residents or staff related to the allegation, and it was not reported to the SA. RN3 stated she interviewed the staff present, did not feel the need to interview other residents or staff and was not aware R80 was afraid of NA9. During an interview on 9/15/2016 at 6:36pm, the administrator stated she was unaware R80 was afraid of NA9. During an interview on 9/16/2016 at 7:00am, the administrator stated that the initial allegation should have been thoroughly investigated and reported to the SA since R80 stated that she was afraid to ask for help. 2. R9's significant change Minimum Data Set (MDS - a federally required assessment) dated 6/1/16 recorded the resident's Brief Interview for Mental Status score a 13 which indicated the resident was cognitively intact. During an interview on 9/13/16 at 11:41am, R9 stated that during dinner on 9/2/16 a nurse had "shouted" at her in the dining room during dinner when she inquired about R7 lunch meal intake. R9 indicated that she had reported the incident to the Administrator on 9/6/16. Record review of the "Suggestion or Concern" form dated 9/6/16, revealed that on 9/6/16 R9 had reported to the Administrator that "she [R9] told the nurse on Friday 9/2/16 that a resident [R7's initials] didn't eat any supper & [and] was wondering if she had eaten any dinner that day. [R9's name] stated [RN7's initials] blew up at her & [R46's initials]. Further review of the document revealed that the investigation only included	F 225	including RN3 and RN7on 10/6/2016 on immediately reporting allegations of resident abuse to the Administrator and the State Agency and thoroughly investigating and reporting final results to the State Agency within 5 working days of the incident. Administrator will be re-educated on conducting an investigation and preventing, recognizing and reporting abuse through on-line training provided by QAPI Consultant on 10/13/2016. Administrator or designee will audit all suggestion/ concern forms and incident reports to ensure that all reportable incidents have been reported immediately to the Administrator and State Agency with appropriate 5 day follow-up. 4. Administrator or designee will audit any allegations of abuse to ensure that the incidents were immediately reported to the Administrator and the State Agency and thoroughly investigated and final results were reported to the State Agency within 5 working days of the incident weekly times 12 weeks. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	

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F 225	Continued From page 4	F 225		

resident and staff interviews from R9, R7 and RN7.

During an interview on 9/16/2016 at 8:36am, the Administrator confirmed that the SA was not notified of the abuse allegation involving R9 and that the results of the final investigation were not forwarded to the State Agency. The Administrator also confirmed that only R9, R7 and RN7 were interviewed about the incident.

3. Review of the "Suggestion or Concern" form, dated 1/27/16, revealed that on 1/27/16 R81 reported to E1 that "a man with short hair being (sic) rough c [with] him while getting [R81] to the bathroom..." Review of the statement from E1, attached to the form, revealed "...noticed pt [patient] had 2 'scratches' 'cuts' on left hand by wrist..." Further review of the document indicated that E1 reported R81's allegation to RN4, who started the investigation.

During an interview on 9/16/16 at 8am, RN4 stated she did not interview any other residents or staff other than the nurse aides that were assigned to care for R81 on the day of the allegation. RN4 further stated that she did not feel the need to interview other residents or staff as there were no male nursing staff on duty that day. RN4 indicated that there was no initial reporting to the facility Administrator or to the SA.

During an interview on 9/16/2016 at 8:36am, the Administrator confirmed that R81's allegation was not immediately reported to the Administrator and the SA and the results of the investigation were not reported to the SA.

During an interview on 9/15/16 at 4:30pm, the

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F 225	Continued From page 5 Administrator stated that abuse allegations are to be reported immediately to the State Agency and a final investigation report is to follow within 5 working days. Review of the facility's "Abuse and Neglect" policy, revised 9/13, pages 1 and 2 of 2, indicated "Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency ...The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency within five working days of the incident, or sooner as designated by state law..."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement its abuse prohibition policy on reporting allegations of abuse for three (R80, R9,	F 226	F226- Develop/ Implement Abuse/ Neglect, Ect Policies	10/24/16

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F 226	Continued From page 6 and R81) of three residents reviewed for abuse investigations. The facility also failed to include policies and procedures that prohibit staff from taking, keeping and/or distributing photographs and recordings that demean or humiliate a resident. This deficiency had the potential to affect all 45 residents residing in the facility. Findings include: 1. During an interview on 9/15/16 at 1:20pm, R80 stated she was "afraid, leery, and did not trust" Nurse Aide (NA9) after NA9 yelled at her, stating "that really upset me, I had to go out to the desk and talk to [NA7] just to calm down." R80 stated that she was still afraid of NA9 because she did not want to be yelled at like that again. Record review of the "Suggestion or Concern" form dated 7/9/16, revealed that R80 reported to Registered Nurse (RN3) that NA9 told R80 to "get up and use [bathroom] herself." R80 reported that NA9 was "rude" and "mocking" the resident the whole time and the resident was "afraid to ask for help now." The form documented that NA9 stated that R80 was trying to "argue" and that NA9 did not feel she was being rude to R80. The form revealed that NA7 was also in the room and reported to RN3 that NA9 was argumentative toward R80. The facility did not have any additional information related to the concern. During an interview on 9/15/16 at 1:55pm, RN3 stated that the allegation was not reported to the Stage Agency (SA). RN3 stated she interviewed the staff present and did not feel the need to interview other residents or staff and was not aware R80 was afraid of NA9.	F 226	1. Incidents involving Residents R80, R81 and R9 were reported to the Administrator and the State Agency on the following dates: a. R9: Reported to Administrator and State Agency on 10/4/2016; investigation was completed and final results were submitted on 10/5/2016. b. R80: Reported to Administrator and State Agency on 9/16/2016; investigation was completed and final results were submitted on 9/21/2016. c. R81: Reported to Administrator and State Agency on 10/4/2016; investigation was completed and final results were submitted on 10/4/2016. The policy and procedure was revised to include that our facility prohibits an employee from taking or using photographs or recordings in any manner that would demean or humiliate a resident. 2. This deficiency has the potential to affect all residents. 3. On 10/3/2016, Administrator provided re-education to RN Unit Managers, Social Services RN, DNS, Rehab RN, MDS RN, Staff Development/ QAPI RN by Administrator on immediately reporting allegations of resident abuse to the Administrator and the State Agency and thoroughly investigating and reporting final results to the State Agency within 5	

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F 226	Continued From page 7 During an interview on 9/16/2016 at 7:00am, the administrator stated that the initial investigation should have been thoroughly investigated and reported to the SA since R80 stated that she was afraid to ask for help. 2. R9's significant change Minimum Data Set (MDS - a federally required assessment) dated 6/1/16 recorded the resident's Brief Interview for Mental Status score a 13 which indicated the resident was cognitively intact. During an interview on 9/13/16 at 11:41am, R9 stated that during dinner on 9/2/16 a nurse had "shouted" at her in the dining room on 9/2/16 during dinner when she inquired about R7 lunch meal intake. R9 indicated that she had reported the incident to the Administrator on 9/6/16. Record review of the "Suggestion or Concern" form dated 9/6/16, revealed that on 9/6/16 R9 had reported to the Administrator that "she [R9] told the nurse on Friday 9/2/16 that a resident [R7's initials] didn't eat any supper & [and] was wondering if she had eaten any dinner that day. [R9's name] stated [RN7's initials] blew up at her & [R46's initials]. Further review of the document revealed that the investigation only included resident and staff interviews from R9, R7 and RN7. During an interview on 9/16/2016 at 8:36am, the Administrator confirmed that the SA was not notified of the abuse allegation involving R9 and that the results of the final investigation were not forwarded to the State Agency. The Administrator also confirmed that only R9, R7 and RN7 were interviewed about the incident.	F 226	working days of the incident. Administrator re-educated all staff including NA9 and RN3 on 10/6/2016 on following the policy and procedure on reporting allegations of abuse (immediately reporting allegations of resident abuse to the Administrator and the State Agency and thoroughly investigate and report final results to the State Agency within 5 working days of the incident) and on the revised policy and procedure that prohibits staff from taking, keeping, and/or distributing photographs and recordings that demean or humiliate a resident. A process was created to aid in the investigation (interviews of residents and staff). Education on investigation interview questions for residents/ staff was completed with all staff on 10/6/2016. Administrator or designee will audit all suggestion/ concern forms and incident reports to ensure that all reportable incidents have been reported immediately to the Administrator and State Agency with appropriate 5 day follow-up. 4. Administrator or designee will audit any allegations of abuse to ensure that the incidents were reported immediately to the Administrator and the State Agency and thoroughly investigated and reported final results to the State Agency within 5 working days of the incident weekly times 12 weeks. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	

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F 226	Continued From page 8	F 226		

3. Review of the "Suggestion or Concern" form, dated 1/27/16, revealed that on 1/27/16 R81 reported to E1 that "a man with short hair being (sic) rough c [with] him while getting [R81] to the bathroom..." Review of the statement from E1, attached to the form, revealed "...noticed pt [patient] had 2 'scratches' 'cuts' on left hand by wrist..." Further review of the document indicated that E1 reported R81's allegation to RN4, who started the investigation.

During an interview on 9/16/16 at 8am, RN4 stated she did not interview any other residents or staff other than the nurse aides that were assigned to care for R81 on the day of the allegation. RN4 further stated that she did not feel the need to interview other residents or staff as there were no male nursing staff on duty that day. RN4 indicated that there was no initial reporting to the facility Administrator or to the SA.

During an interview on 9/16/2016 at 8:36am, the Administrator confirmed that R81's allegation was not immediately reported to the Administrator and the SA and the results of the investigation were not reported to the SA.

During an interview on 9/15/16 at 4:30pm, the Administrator stated that abuse allegations are to be reported immediately to the State Agency and a final investigation report is to follow within 5 working days.

Review of the facility's "Abuse and Neglect" policy, revised 9/13, pages 1 and 2 of 2, indicated "Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to

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F 226	Continued From page 9	F 226		

the center administrator and to other officials in accordance with state law, including the state survey and certification agency...The center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator or designated representative and to other officials in accordance with state law, including to the state survey and certification agency within five working days of the incident, or sooner as designated by state law..."

During an interview on 9/16/16 at 8:30am, the Administrator was made aware and confirmed that the facility abuse prohibition policies and procedures failed to include procedures to ensure nursing home staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s).

Review of the facility's "Social Networking" revised 8/15, "Abuse and Neglect" revised 9/13, "Abuse Definitions" issued 2/13, and "Abuse and Neglect" revised 8/15 policies failed to include policies and procedures to include and ensure that nursing home staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s), including mental abuse.

Review of the Centers for Medicare & Medicaid Services (CMS) "Survey and Certification Memorandum 16-33-NH", dated 8/5/16, indicated "Each resident has the right to be free from all types of abuse, including mental abuse. Mental abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking

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GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 10 or using photographs or recordings in any manner that would demean or humiliate a resident(s)...Each nursing home must develop and implement written policies and procedures that prohibit all forms of abuse, including mental abuse. Each nursing home must review and/or revise their written abuse prevention policies and procedures to include and ensure that nursing home staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). This would include using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and recordings on social media."	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to offer alternate food choices during activities for two (R30, R9) of two residents reviewed for activities in the Stage 2 sample of 35. Findings included: 1. A. R30's diagnosis from the 9/2016 electronic record included diabetes mellitus.	F 248	F248- Activities Meet Interests/ Needs of each resident 1. R30 and R9 are being provided a comparable alternative food choice during activities in which snacks are involved. 2. All residents who need a comparable alternate food choice during activities have the potential to be affected by this deficiency. Activity Director receives an	10/24/16

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F 248	Continued From page 11 R30's admission Minimum Data Set (MDS - a federally required assessment) dated 7/7/16 recorded the resident's Brief Interview for Mental Status score a 13 which indicated the resident was cognitively intact. During an interview on 9/13/16 at 8:50am, R30 stated she was not able to participate in the pie socials, happy hour, or birthday parties because they did not offer an alternative food that she could eat due to her diabetes. B. R9's diagnosis from the 9/2016 electronic record included diabetes mellitus. R9's significant change MDS dated 6/1/16 recorded the resident's Brief Interview for Mental Status score a 13 which indicated the resident was cognitively intact. During an interview on 9/15/16 at 10:28am R9 expressed a concern related to facility activities. R9 indicated that the majority of the activities involve food activities with no food alternates for residents with special diets. R9 stated, "We just had pie day yesterday. I am diabetic, I can't eat that. I told them [facility] that." During an observation on 9/14/16 at 2:20pm revealed several residents gathered in a living area eating pie. Review of the facility's September 2016 activity calendar revealed the following information: Bake day-9/6, 9/13, 9/20, 9/27 Pie social-9/7, 9/14, 9/21, 9/28 During an interview on 9/15/16 at 12:40pm, the Activity Director (AD1) stated if a resident was not	F 248	ongoing list of residents with a diagnosis of diabetes who have diet restrictions and will work with residents to ensure that there will be comparable alternative food choices during activities in which snacks are offered. 3. On 10/4/2016, Staff Development/ QAPI RN re-educated the Activity Director and Activity Department Staff that we will provide a comparable alternate food choice during activities. 4. Activity Director or designee will conduct audits to ensure there were comparable alternate food choices available at activities for residents with a diagnosis of diabetes. These audits will be completed two times per week times four weeks, then once per week times four weeks. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	

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F 248	Continued From page 12 able to eat the food served, such as the pie, they are offered yogurt or Jello. AD1 stated that typically the area churches brought in the cakes for the birthday parties and the facility did not provide an alternative food choice during the parties.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a comprehensive sleep hygiene care plan related to the use of trazodone (a medication used for sleep) for one (R30) of five residents reviewed for medication in the Stage 2	F 279	F279- Develop Comprehensive Care Plans 1. Comprehensive sleep care plan related to the use of trazadone for sleep	10/24/16

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F 279	Continued From page 13 sample of 35. Findings included: R30's diagnosis from the 9/2016 electronic record included insomnia, major depressive disorder, and schizoaffective disorder (a condition that may cause hallucinations, delusions, or depression). R30's admission Minimum Data Set (MDS - a federally required assessment) dated 7/7/16 recorded the resident's Brief Interview for Mental Status score a 15 which indicated the resident was cognitively intact. R30's 7/13/16 Psychotropic Care Area Assessment (CAA) recorded the resident did not have a diagnosis of insomnia, received trazodone as needed, and had been requesting trazodone every night. R30's 7/13/16 care plan did not include the use for trazodone as needed or interventions related to difficulty sleeping. R30's 7/14/16 electronic orders recorded an order on 7/14/16 for trazodone hydrochloride (HCL) 25 milligrams (ml) by mouth daily for insomnia. During an interview on 9/16/16 at 8:27am, the Director of Nursing (DON) stated that the resident requested trazodone every night and used it nightly prior to admission to the facility, so a care plan was not developed for it.	F 279	disturbance was added to care plan for R30 on 9/19/2016. 2. All residents who have been prescribed trazadone have the potential to be affected by this deficiency. 3. Administrator re-educated RN Unit Managers on developing a comprehensive sleep hygiene care plan related to the use of trazadone on 10/6/2016. A procedure was developed and implemented to have the RN Unit Managers notify MDS RN when there are medication changes related trazadone which will need to be added to the care plan. 4. Director of Nursing or designee will audit care plans of residents who have been prescribed a medication related to trazadone three times for one month, then two times a month for two months. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312		10/24/16

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F 312	Continued From page 14 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide complete perineal care following an incontinence episode for one (R47) of one dependent residents observed for incontinence care in the Stage 2 sample of 35. Findings included: R47's diagnoses from the September 2016 electronic record included Parkinson's disease, stage III pressure injury, hypertension, vitamin deficiency, dementia, nutritional deficiency, and osteoarthritis. The admission 5/24/16 Minimum Data Set (MDS- a federally required comprehensive assessment) recorded R47 had short and long term memory impairment, was totally dependent on staff for personal hygiene, and was incontinent of bowel and bladder. The 5/24/16 care plan recorded R47 was incontinent of urine and interventions directed staff to check the resident every hour while awake, every two hours at night, and as needed. The 5/31/16 Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) recorded R47 had dementia and Parkinson's disease, was unaware of voiding (urinating) urges, and was not	F 312	F312- ADL Care Provided for Dependent Residents 1. R47 is receiving complete perineal care following an incontinence episode. 2. All residents who are incontinent have the potential to be affected by this deficiency. 3. Administrator completed re-education on procedure for perineal care on females on 10/6/2016 with the Nursing Department. Nursing Assistants have been assigned to complete an on-line training titled: Perineal and Catheter Care. Director of Nursing or designee will complete perineal care competency with NA3 and NA4 by 10/24/2016. 4. Director of Nursing or designee will conduct observation audits to ensure perineal care is being provided for residents who are incontinent. Observation audits will be completed three times a week on am shift and three times a week on pm shift times four weeks, then one time per week on am and pm shifts for four weeks. Audit results will be reviewed by the QAPI Committee for further recommendations.	

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F 312	Continued From page 15 able to verbalize toileting needs. During an observation on 9/15/16 at 9:12am, revealed Nurse Aide (NA3) and NA4 transferred R47 from the wheel chair into bed via a Hoyer lift (a mechanical lift). NA3 and NA4 removed R47's pants and unfastened the incontinence brief. The brief was visibly saturated with urine and NA4 confirmed the brief was wet. NA3 rolled R47 onto the left side and NA4 removed the brief and wiped R47's buttock area with a wet cleansing cloth. NA3 and NA4 did not cleanse R47's left buttock or genital area between R47's legs that was exposed to urine. During an interview on 9/16/16 at 8:36am, the Director of Nursing (DON) stated that staff should have cleansed the entire area that was exposed to urine. The 5/2016 facility provided "Procedure Perineal Care" recorded under the title "Purpose" to keep the perineal area clean, and prevent infection and odors in the perineal area. Under the title "For females: a." recorded "separate the labia with one hand and wash with the other, using gentle downward strokes from the front to the back of the perineum."	F 312	5. Correction will be completed by: 10/24/2016	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		10/24/16

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F 314	Continued From page 16 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain the necessary care and treatment to prevent wound contamination for one of three (R47) residents with skin pressure injuries in the Stage 2 sample of 35. Findings included: R47's diagnoses from the September 2016 electronic record included Parkinson's disease, stage III pressure injury, hypertension, vitamin deficiency, dementia, nutritional deficiency, and osteoarthritis. The admission 5/24/16 Minimum Data Set (MDS- a federally required comprehensive assessment) recorded R47 had short and long term memory impairment, was totally dependent on staff for personal hygiene, was incontinent of bowel and bladder and did not have a pressure ulcer. The 9/9/16 care plan recorded R47 was incontinent of urine, had a dressing on the coccyx (a small, triangular bone at the base of the spinal column) and recorded "please alert nurse if soiled or loosens." During an observation on 9/15/16 at 9:12am, revealed Nurse Aide (NA3) and NA4 transferred R47 from the wheel chair into bed via a Hoyer lift (a mechanical lift). NA3 and NA4 removed R47's pants and unfastened the incontinence brief. The	F 314	F314- Treatment/ Services to Prevent/ Heal Pressure Sores 1. Nursing Assistants providing care for R47 are reporting soiled or loosened dressing to nurse. 2. All residents with dressings have the potential to be affected by this deficiency. 3. Administrator completed re-education to all nursing staff including NA3 and NA4 on maintaining the necessary care and treatment to prevent wound contamination on 10/6/2016. 4. Director of Nursing or designee will conduct observation audits to ensure wound dressings are intact and Nursing Assistant will report to nurse if wound dressing is soiled or loosened. Observation audits will be completed three times a week on am shift and three times a week on pm shift times four weeks, then one time per week on am and pm shifts for four weeks. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	

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F 314	Continued From page 17 brief was visibly saturated with urine and NA4 confirmed the brief was wet. Observation revealed a white bandage approximately four inches by four inches that was wet, loosened half way and exposed the Stage III pressure ulcer on R47's coccyx. NA3 and NA4 put a clean brief on the resident and did not alert the nurse at this time of the condition of the dressing. During an interview on 9/15/16 at 11:25am, the Registered Nurse (RN6) stated the NA's did not report that the dressing was loose or wet. RN6 stated the resident received a bath this morning and the NA removed the dressing. RN6 stated she did not observe the dressing prior to staff removing it. RN6 stated that she should have observed the dressing for any drainage before the NA removed it prior to the bath and would expect the NA's to report if the dressing was soiled or loose after incontinence episodes so the dressing could be changed. During an interview on 9/15/16 at 2:49pm, the unit manager, RN2, stated the nurse aides should have reported the soiled, loose dressing to the nurse immediately.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		10/24/16

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F 323	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure that chemicals and other liquid products, intended for external use, and personal grooming accessories were appropriately secured. The deficient practice had the potential to affect five residents identified as cognitively impaired and ambulatory (R3, R7, R13, R18, R25). Findings include: 1. On 9/12/16 at 4:45pm the door to the wheelchair cleaning room, located on the 300 unit, was open and there was a cardboard box which sat next to the door that read, "Please Leave Door Open." This message was written in black marker. The following was observed in this cleaning room: -There were 2 boxes of "Carpet Pre-Spray." Each plastic container had 1 (United States) US gallon. On each gallon container was the following warning, "keep out of reach of children." -There was 1 opened plastic container of "Liquid Odor Control." This bottle identified that it was to be for external use only. -There were 3 bottles which each contained 1 US gallon of "Extraction Cleaner" industrial strength and each container was sealed. -There were 2 bottles and each contained 1 US gallon of "Top Clean" and each container was sealed. The MSDS read, "Wash thoroughly after handling. Avoid contact with eyes. Do not take	F 323	F323- Free of Accident Hazards/ Supervision/ Devices 1. R3, R7, R13, R18 and R25 are now able to ambulate freely without access to chemicals, and other liquid products, intended for external use, personal grooming accessories. Wheelchair cleaning room was locked on 9/12/16 and cardboard box sign was removed. Chemicals were removed from the closet by the Chapel on 9/12/16. Locking cabinets were placed in both tub rooms to secure chemicals on 10/4/2016. Soiled utility room keypad is in working condition and door is shut and secure. 2. This deficiency has the potential to affect all residents who are cognitively impaired and ambulatory. 3. Education was provided by Maintenance Supervisor to outside contracted agency on locking wheelchair room when not in use. Locking cabinets are now in both tub rooms to secure the chemicals. Administrator completed re-education with every department on ensuring chemicals and other liquid products, intended for external use, and personal grooming accessories are appropriately secured and doors shut on 10/6/2016. 4. Maintenance Supervisor or designee will audit that tub room cabinets with chemicals are locked, soiled utility room	

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F 323	Continued From page 19 internally." -One bottle of "Top Clean" and it was opened and unsecured. -There were 2 bottles, each containing 1 US quart of "General Purpose Spot." These containers were sealed. The MSDS read "CAUTION. CAUSES EYE IRRITATION. MAY BE MILDLY IRRITATING TO SKIN." -One bottle of "Virex II 256" and this bottle was opened and stated to "Keep out of Reach of Children." -One bottle of "Spit Fire NBSC" and this bottle had a warning label which stated "Keep out of Reach of Children." This was 2.64 US quart bottle and this bottle open. -An area that was designated to clean wheelchairs had cleaning chemicals secured on the walls that could be dispensed. There was a cabinet on the wall located in the wheelchair cleaning room and the following was observed in this cabinet: -One bottle of "Medco Rinse MR 1040," 1 US gallon, and this container was open. This bottle was labeled to "Keep out of Reach of Children." - "Dawn" soap, 1.12 Liter and it read to "Keep out of Reach of Children" and this plastic bottle was half full. -"Sorb-it" 16 ounces (oz) and had a warning label to "Keep out of Reach of Children."	F 323	key pad is in working order, wheelchair cleaning room is closed and locked at all times. Audit will be completed daily times two weeks, then 3 times per week times 2 weeks, then once per week for four weeks. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	

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F 323	Continued From page 20	F 323		

An interview was conducted with a licensed practical nurse (LPN) 12 on 9/12/16 a 4:55pm LPN 12 stated the door was usually kept open. She said she thought the door needed to be shut. She then said she was going to shut and lock the door.

2. On 9/15/16 at 9:06am the following was observed on the 200 unit shower room:

-The door to the shower room was unlocked and inside was a housekeeping cart. On the housekeeping cart was a spray bottle which was labeled "Glass and Plastic Cleaner" and on the plastic spray bottle a labeled warning read to "Keep out of Reach of Children" and that the contents could cause skin and eye irritation.

-There was a single bathing tub and on each side of the tub were floor cabinets. The cabinet to the left of the tub had a pair of nail clippers and baby oil, a spray can of antiperspirant, and a body fragrance mist spray. Underneath the drawers there was a cabinet, which was unlocked, and contained a spray bottle of "Virex 256" disinfectant cleaner. This bottle had a warning label which read to "Keep out of Reach of Children."

-Two generic bottles of baby oil which read for "External Use Only."

-There was a towel rack and on the bottom shift the following was observed:

-Three bottles of "Classic Bath Additive and Skin Conditioner" each was 1 US gallon and had identified the product was "For External Use Only."

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-One 3-liter bottle of "Classic Whirlpool Disinfectant Cleaner" and was labeled with a warning to "Keep out of Reach of Children...danger."

An interview was conducted on 9/15/19 at 8:45am, with the maintenance director. The maintenance director said that the wheelchair cleaning room was maintained by an outside company that cleaned the facility and cleaned the wheelchairs each week for the residents. He stated he had already spoken with them about keeping this area locked. The maintenance director was then taken to the shower room on the 300 unit. The maintenance director stated that he was a new employee and had not identified the problem prior to the survey.

A facility document entitled "Residents that are cognitively impaired and are independent with mobility" was reviewed. The following residents were identified to reside on the 200 unit: Resident (R) 7, R25, and R18. The following residents were identified as ambulatory and cognitively impaired on the 300 unit: R13 and R3.

3. On 9/12/16 at 4:42pm during the initial tour of the facility, observation revealed a closet next to the chapel and living area with the following chemicals stored: a spray bottle labeled "one step disinfectant cleaner and deodorant, "Virex II 256," with 240 milliliters (ml) of fluid in it, a plastic bottle of "Pad Treatment" sixteen ounce fluid approximately three fourths full with a label affixed that read "keep out of reach of children" and "harmful if swallowed," and a 1 quart spray bottle of "Glass and Plastic Cleaner, Green Advantage" with a label affixed that read "wear

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F 323	Continued From page 22	F 323		

neoprene or nitrite rubber gloves and protective clothing when handling." The closet door did not have a lock on it. Observation of the soiled utility room revealed a push button lock on the door and was not secured. Inside the room revealed the same chemicals observed in the closet by the chapel as well as a large jug, approximately 2-3 gallons of Virex II 256 concentrate that had a turning pour spout toward the bottom of it.

On 9/12/16 at 5:07pm during continuation of the initial tour of the 200 hall, observation revealed the shower room door unlocked and on each side of the bath tub were plastic cabinets with the doors and drawers opened and contained large nail clippers and large nail nippers (Plier type cutters), multiple disposable razors, a 6 ounce spray can of Arrid Extra Dry deodorant spray with a warning on the can that recorded "keep away from mouth and face," a spray bottle of Virex II 256, two three liter containers of "Classic Whirlpool Disinfectant" and the affixed label that recorded the following warning if it came in contact with eyes or skin, "irreversible eye damage and skin burns."

During an interview on 9/12/16 at 4:49pm, the Activity Director (AD1) stated the chemicals have always been stored in the closet and not locked. At this time AD1 removed the chemicals from the closet.

During an interview on 9/12/16 at 5:07pm, the Licensed Practical Nurse (LPN12) stated staff did not lock the shower room door or the cabinets on each side of the bath tub and stated the soiled utility room door should have been closed and secured. LPN 12 stated they had problems with the door not closing.

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F 323	Continued From page 23 According to the Material Safety Data Sheet (MSDS) for Virex II 256 One- Step Disinfectant Cleaner and Deodorant the chemical "Principle routes of exposure: Eye contact: corrosive. Causes permanent eye damage, including blindness. Skin contact: Corrosive. Causes permanent damage. Inhalation: May cause irritation and corrosive effects to nose, throat and respiratory tract. Ingestion: May be irritating to mouth, throat and stomach." According to the MSDS for "Glass and Plastic Cleaner, Green Advantage" under the title "Section V - Health and Hazard Data" recorded the following: "Effects of Overexposure:" under the title, "Acute: (Short Term Exposure) Eye contact: causes irritation seen as tearing and redness. Skin contact: causes irritation seen as itching and redness. May cause allergic skin reaction seen as delayed skin rash which may be followed by blistering, scaling, and other skin effects. Prolonged or repeated contact as from clothing wet with material may cause drying. Defatting (chemically dissolving fat from the skin), and cracking of the skin. Inhalation: may cause irritation seen as coughing and sneezing. Ingestion: may cause irritation seen as nausea, vomiting, and diarrhea. The facility did not provide a policy related to the storage of chemicals.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		10/24/16

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F 371	Continued From page 24 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observations and interview the facility failed to store, prepare, distribute and serve food under sanitary conditions to all 45 residents residing in the facility.

The findings include:

1. On 9/12/16 at 4:45pm the initial tour of the kitchen was conducted.

The hand washing sink was without paper towels or any towels to dry hands. There was a dirty wash cloth left in the sink.

A metal shelf in the dishwashing room was observed to have several red buckets on the third shelf. One of the buckets was 3/4 full of a white with splashes of flesh-colored coagulated substance in it. It looked like lard and chicken fat.

The dry storage area was observed to contain onion peelings on the trays below the box of onions. One #10 can of sliced apples was dented.

On the food preparation table near the walk-in refrigerator/ freezer several pans were observed stacked on the bottom shelf, they contained dried food and debris.

F371- We will correct the deficiency as it relates to the individual (s) or others by:

1. All residents were impacted by this deficiency.

" Paper towels were added to the hand washing sink and dirty wash cloth was removed from the sink on 9/12/2016. Process has been developed to ensure extra paper towels are on hand.

" Food preparation table near walk-in refrigerator/ freezer had pans stacked on bottom of shelf- shelf has been cleaned and sanitized. Dietary Supervisor has developed and implemented procedure with staff that this shelf will be wiped down every evening.

" Dirty towels and aprons were removed from the top of the trash bin. This bin is for soiled linen only. On 10/6/2016, Dietary Supervisor labeled the bin to be used only for soiled linen.

" Dented can of sliced apples and two boxes of muffins which were not labeled or dated were discarded on 9/15/2016.

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F 371	Continued From page 25 There were dirty towels and aprons on top of a trash bin that was also soiled with dried food and liquids, near the 3-1 compartment sink. On the food preparation table, as well as on top of the meal tray cart, there were unlabeled cookies, muffins and brownies. There was no sanitizing solution in the sanitation buckets in the main dining room, just wet white cloths. The ice cream drip tray was observed to have ice cream build-up on it, although it had not yet been used for the dinner meal. 2. On 9/15/16 at 7:50am a final inspection of the kitchen was completed. The dented #10 can of sliced apples remained on the shelf and two boxes of muffins were not labeled or dated. 3. On 9/15/16 at 7:55am the Dietary Manager (DM) was asked if he knew what had been stored in the red sanitation buckets and was told what the substance looked like. He stated that he did not have any idea what was in the bucket and he had not seen the buckets. 4. On 9/12/16 at 4:50pm the walk-in refrigerator was found to have a wet floor near the freezer door. There was a pan of chicken thawing, the pan was filled full of chicken, and the juice of the chicken was observed overflowing into an empty pan below as well as onto a box of chicken stored on the floor and also onto the floor.	F 371	Food Receiving Policy and Procedure has been implemented with the dietary staff. The unlabeled cookies, muffins and brownies on the food prep area and on top of meal tray cart were discarded on 9/12/2016. Unlabeled/ undated food- pan of cooked sausage, mashed potatoes, scalloped potatoes, brown gravy, bags of lettuce, cubed cheese, shredded cheese, bag of radishes were discarded on 9/16/2016. Peeled potatoes in large white trash- barrel which was dated 9/8/2016 were discarded. The Food Storage Policy and Procedure and Leftover Policy and Procedure have both been implemented with the dietary staff. " Ice cream drip tray was cleaned and sanitized. Dietary Supervisor has developed and implemented procedure that the ice cream drip tray will be monitored daily and cleaned daily. " Wet floor near freezer door was cleaned on 9/16/2016. Dietary cooks have attended Serve Safe classes on 9/27/2016, 9/29/2016, and 10/4/2016. Dietary Supervisor discussed Thawing Food Procedure with staff on 9/16/2016. Thawing Food Procedure has been implemented with dietary staff. " Red buckets in the dishwashing room were emptied, cleaned and sanitized on 9/12/2016. Registered Dietician reviewed Sanitizing Solutions Procedure on 10/7/2016 with dietary staff. Sanitizing Solutions Procedure has been implemented with dietary staff.	

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F 371	Continued From page 26 There was a pan of cooked sausage observed cooling on a baking tray in a storage rack that was stored in the refrigerator; it was not covered. There were three 1/3 steam table pans of mashed potatoes that were not covered or labeled, one 1/4 steam table pan of scalloped potatoes and brown gravy not labeled or covered. There were three bags of lettuce, 3 bags of cubed cheese, one bag of shredded cheese and one bag of radishes wrapped in Saran wrap, but were not labeled or dated. A large white trash-barrel full of peeled potatoes and water was observed, it had a date of 9/8/16 on the lid. On 9/15/16 at 8:15am the DM stated that evening shift often left the food uncovered and not labeled in the walk-in refrigerator and he usually just tossed it in the mornings. He did not discuss what trainings he had done with the evening shift regarding proper labeling and storage of foods. 5. According to the Minnesota Administrative Rules, Chapter 4626, Food Code; Food Managers (electronically published on 10/11/09), "4626.0225 3-301.11 PREVENTING CONTAMINATION FROM HANDS.* A. Food employees shall wash their hands as specified in part 4626.0070 <https://www.revisor.mn.gov/rules/?id=4626.0070>. B. Except when washing fruits and vegetables as specified in part 4626.0255 <https://www.revisor.mn.gov/rules/?id=4626.0255>, food employees shall limit direct hand contact with exposed, ready-to-eat food when deli tissue, spatulas, tongs, dispensing equipment, or other utensils can be used.	F 371	" Food Temperatures are recorded for every cooked to and served to meal time. Dietary Department meeting has been scheduled for 10/11/2016 to discuss implementation of Food Temperatures Policy and Procedure. 2. This deficiency has the potential to affect all residents. 3. Re-education was completed at the all staff meeting on 10/6/2016. All Cooks in the Dietary Department have attended Serve Safe classes on 9/27/2016, 9/29/2016 and 10/4/2016. Dietary Department meeting has been scheduled for 10/11/2016. On 10/6/2016, all staff were re-educated on delivering drinking glasses appropriately without touching the rim. On 10/6/2016, all staff were re-educated on sanitizing hands per facility process during meal times and with food preparation. On 10/5/2016, Dietary Supervisor re-educated cook on when to wash hands when preparing raw and cooked foods. On 10/6/2016, Dietary Supervisor re-educated staff member on use of gloves/ when to change gloves and hand washing. Dietary Supervisor re-educated dietary staff members on utilizing hair restraints per facility policy and procedure. All dietary staff are utilizing hair restraints per facility policy and procedure. 4. Dietary Supervisor or designee will complete audits on food temperatures, thawing food, leftovers/ food storage, food	

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F 371	Continued From page 27 Food employees shall minimize bare hand and arm contact with exposed food that is not in a ready-to-eat form. Except when wounds or lesions are present as described in part 4626.0040 <https://www.revisor.mn.gov/rules/?id=4626.0040>, single-use gloves are not required if proper handwashing as specified in parts 4626.0070 <https://www.revisor.mn.gov/rules/?id=4626.0070> to 4626.0090 <https://www.revisor.mn.gov/rules/?id=4626.0090> is undertaken. 4626.0070 2-301.12 CLEANING PROCEDURE.* A food employee shall clean the hands and exposed portions of the arms with a cleaning compound in a handwashing lavatory in the food preparation area that is equipped as specified in part 4626.1050 <https://www.revisor.mn.gov/rules/?id=4626.1050>, item A, by vigorously rubbing together the surfaces of the lathered hands and arms for at least 20 seconds and thoroughly rinsing with clean water. An employee shall pay particular attention to the areas underneath the fingernails and between the fingers by scrubbing thoroughly with a nail brush. 4626.0075 2-301.14 WHEN TO WASH.* A food employee shall clean the hands and exposed portions of the arms as specified in part 4626.0070 <https://www.revisor.mn.gov/rules/?id=4626.0070> at the following times: A. After touching bare human body parts other than clean hands and clean, exposed portions of arms; after defecating, contacting body fluids and discharges, or handling waste containing fecal matter, body fluids, or body discharges; and before beginning or returning to work; B. After using the toilet, at a handwash lavatory,	F 371	receiving and infection control daily at each meal times four weeks, then three times per week at each meal times four weeks, then one time per week for each meal times four weeks, then review at QAPI. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	

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F 371	Continued From page 28 in the toilet room; C. After caring for or handling support animals as allowed in part 4626.0120 <https://www.revisor.mn.gov/rules/?id=4626.0120 >; D. After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; E. After handling soiled equipment or utensils; F. Immediately before engaging in food preparation including working with exposed food, clean utensils, and unwrapped single-service and single-use articles in the food preparation area; G. During food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks; H. When switching between working with raw foods and working with ready-to-eat foods; or I. After engaging in other activities that contaminate the hands." a. On 9/12/16 at 5:45pm in the dining room certified nurse aide (CNA) 10 was observed grabbing drinking glasses by the rim when assisting two dependent residents with fluids, wiping their mouths with the clothing protectors and not a napkin. She was observed getting up to assist R50 who was able to feed herself with cueing, CNA10 moved her plate and glasses closer and also assisted her with a bite of food to encourage her to continue eating; she did not sanitize her hands during the entire meal period. b. On 9/15/16 from 8:12am until 8:32am the Cook was observed wearing the same pair of gloves to prepare all cooked foods for breakfast. She did not change her gloves after she had cracked open eggs and touched the ladle used for	F 371		

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F 371	Continued From page 29 pancake mix as well spatulas and tongs. c. On 9/15/16 from 8:12am until 8:32am dietary staff (DS) 4 was observed wearing the same pair of gloves throughout the meal preparation. She opened drawers and removed clean utensils, handled a knife to butter the toast that was lying on the counter, opened bread bags, and removed the bread to toast and closed the bags wearing the same pair of gloves. She entered the main dining room and pushed a gray cart into the dining room with the same pair of gloves and then returned to the kitchen and dished up oatmeal from the steam table. She did not change her gloves during the entire observation. 6. Review of the "Cleaning-Sanitation of Non-Food Contact Surfaces" issued in February 2013 identified in pertinent part: "Purpose To provide guidelines for center non-food contact surfaces in the dietary department. Policy The center will store, prepare, distribute and serve food under sanitary conditions at all times. Procedure 1. Cleaning and sanitizing surfaces is a two-step process. Surfaces first must be cleaned and rinsed before being sanitized. 2. Wiping cloths must remain in sanitizing solution until used. Cloths must be rinsed before returned to sanitizing solution. 3. Sanitizing solutions must be checked with test strips for proper solution strength." According to Global Sensors, available at <http://www.global-sensors.com/>, a seller of safety food products defined quat in pertinent part	F 371		

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F 371	Continued From page 30 as: An "active against a wide variety of microorganisms. Unlike bleach, 'quats' are odorless and colorless. And, also unlike bleach, they are non-corrosive, so they will be safer to use over time with metal equipment and surfaces. Their antimicrobial action is varied and selective, but they are generally as effective as bleach/ chlorine solutions. The standard for 'quat' mixing is 200 PPM. There are over 40 suppliers that provide 'quat' sanitizing concentrates. Each one needs testing to be sure that appropriate concentration has been achieved . . . Why Use Test strips? The answer is simple: you don't always get 'quat' solutions of the right strength, even if you follow mixing instructions. What causes this? Sometimes water used for 'quat' preparation contains natural chemicals that work to weaken the solution and sometimes the 'quat' concentrate itself has lost strength." On 9/15/16 at 8:10am there was one red bucket observed containing a solution as well as multiple white cloths sitting in the solution on the back food prep table. On 9/15/16 at 8:20am the DM stated they used a quat solution from Eco lab. When asked how often he tested the solution, he stated "never, Eco lab tested it monthly." He was asked where the test strips were and he said he did not have any, he was asked about the "Hydrion QT-10 (three containers)" test strips observed sitting above the 3-1 compartment sink. The DM stated that he did not think they were any good as they had been there since he started two years ago and he would not trust them. 7. According to the Minnesota Administrative	F 371		

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F 371	Continued From page 31 Rules, Chapter 4626, Food Code; Food Managers (electronically published on 10/11/09), "4626.0340 3-401.11 RAW ANIMAL FOODS.* A. Except as specified in items B and C, raw animal foods, including eggs, fish, poultry, meat, and foods containing these raw animal foods, shall be cooked to heat all parts of the food to a temperature and for a time that complies with one of the following methods based on the food that is being cooked: (1) 63 degrees C (145 degrees F) or above for 15 seconds for: (a) raw shell eggs that are broken and prepared in response to a consumer's order and for immediate service; and (b) except as specified in subitems (2) and (3) and item B, fish and meat including game animals commercially raised for food as specified in part 4626.0160 <https://www.revisor.mn.gov/rules/?id=4626.0160 >; (2) 68 degrees C (155 degrees F) or above for 15 seconds or the temperature specified in the following chart that corresponds to the holding time for pork; ratites; injected meats; the following if they are comminuted: fish, meat, and game animals commercially raised for food as specified in part 4626.0160 <https://www.revisor.mn.gov/rules/?id=4626.0160 >; and raw eggs that are not prepared as specified in subitem (1), unit (a): . . . (3) 74 degrees C (165 degrees F) or above for 15 seconds for poultry; wild game animals specified in part 4626.0160 <https://www.revisor.mn.gov/rules/?id=4626.0160 >; stuffed fish; stuffed meat; stuffed pasta; stuffed poultry; stuffed ratites; or stuffing containing fish, meat, poultry, or ratites."	F 371		

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b. Review of the "Food Temperature Record" revised June 2009 dated 9/11/16 through 9/17/16 revealed staff were logging temperatures. The form read to "please record the following for the boxes with slashes", with a diagram stating "Cooked to" and "Served to". The boxes with slashes for breakfast were, eggs (regular and puree) and meat (regular and puree). The lunch and dinner boxes were meat/ main dish regular, ground and puree, meat/ Alternative and casserole (regular and puree). There was only one temperature recorded on the form.

On 9/15/16 at 8:20am the DM stated he did not record the cooking temperatures, only the serve to temperatures. He stated the State had pointed out that "Food Temperature Record" required cooked to and served to temperatures. He stated he probably should start doing that. The serve to temperatures recorded on the log were at a cooking temperature standard and therefore there was no concern for food-borne illness.

c. Policy and Procedure: "Food Temperatures"

Review of the "Food Temperatures" policy and procedure first revised in March 2009 read in pertinent part:
"Purpose
To reinforce Hazard Analysis Critical Control Point (HACCP) guidelines and state and
federal regulations regarding food temperatures.
Policy
Food temperatures will be taken and recorded before each meal service. Food will be cooked, reheated or cooled to ensure proper serving temperatures before each meal service. Periodically, temperatures will be taken at the end of meal service to ensure temperatures are

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GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 33 held within acceptable ranges. Procedure 1. Prior to meal service, the cook/ designee will take the "cook-to" and "serve" temperatures of all menu items and record on Food temperature Record (GSS #457). 2. To correctly take temperatures, the food thermometer will be inserted into the center or thickest part of the food for at least 15 seconds (or per instructions of thermometer). The thermometer will not touch the pan sides or bottom or the bone in meat . . . 9. Thermometers will be calibrated on a weekly basis to ensure correct temperatures." 8. According to the Minnesota Administrative Rules, Chapter 4626, Food Code; Food Managers (electronically published on 10/11/09), "4626.0115 2-402.11 HAIR RESTRAINTS; EFFECTIVENESS. A. Except as provided under item B, a food employee shall wear a hat, hair covering, net, or other hair restraint, a beard restraint, and clothing that covers body hair, all of which are designed and worn to effectively keep hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles." On 9/13/16 at 4:05 p.m. DS1 and DS3 were observed setting up the main dining room for dinner. Both dietary staff (DS) were wearing blue bonnet hair nets, DS1 did not have the front of her hair tucked in and DS3 did not have her hair tucked in completely in the back. On 9/15/16 at 11:04am DS1 was observed wearing a blue bonnet hair net in the main dining room setting up for lunch, the front of her hair was not tucked in.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

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F 371	Continued From page 34 On 9/15/16 at 3:55pm DS1 was observed wearing a blue bonnet hair net in the main dining room setting up for dinner, the front of her hair was not tucked in. 9. On 9/15/16 at 3:30pm the RD was interviewed. She stated she was a contracted employee and usually came in weekly. She discussed that in April 2016 she began coordinating in-services with the SDC and Speech Language Pathologist (SLP), who was also a contracted employee, as they had identified concerns regarding infection control, dysphagia diets, how to handle ready to eat foods, proper documentation and labeling and storing of foods. She stated the trainings took longer than she had expected as it was difficult to coordinate an in-service with the SLP. She stated that it was her expectation to have all foods covered, labeled and dated. She was uncertain regarding the storage of the peeled potatoes in water but stated they would have the same three day rule as all other food storage. If not used within 3 days, then the food would be tossed out. She discussed not approving of the chicken being thawed on the second shelf, being so full it overflowed onto the floor and on other items. It was the policy and expectation and the "Food Temperature Record" outlined that both the cooked to and served to temperatures should be recorded on the form at every meal. On 9/15/16 at 3:55pm the RD did a walk-through of the kitchen to see the identified issues. She corrected DS1 as she did not have her bangs tucked into her hair bonnet. She observed that the dented #10 can of sliced apple was still in the dry storage as well as one additional #10 that she identified and removed. She stated that all dented	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

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F 371	Continued From page 35 cans were to be left off the shelf and returned or discarded. She also observed that there were muffins left out with no date as well as some brownies. She was shown the "quat" buckets which were full and had two white cloths in them. She stated she was not aware these should be tested with every use to ensure the proper part per million (ppm) as Ecolab tested the solution in all her buildings monthly, but she would order new strips and ensure staff were testing the solution. She observed that a used pair of gloves was left on one of the prep tables and replied, "I certainly see what you are seeing." She stated it had been an ongoing issue regarding gloves for single use tasks, hand washing and how to handle ready-to-eat foods. She discussed that they had done many trainings regarding these issues and she would need to look further into why they were not following policy and procedures.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		10/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

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F 431	Continued From page 36 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that a medication was appropriately labeled to reflect the current physician orders for one resident (R74) in the Stage 2 sample of 35. Findings include: Observations on 9/14/16 at 3:31pm revealed R74 was administered oxycodone 5mg one tablet by mouth. The medication label affixed to the oxycodone 5mg blister pack from which the medication was administered to R74 indicated the following directions: "...5mg by mouth prn [as needed]..." At the time of the observation RN7 had indicated that R74's oxycodone 5mg order was changed from prn to bid [twice daily] and that the pharmacy should have been notified of	F 431	F431- Drug Records, Label/ Store Drugs & Biologicals 1. Pharmacy was notified of change in physician order for oxycodone for R74 and new label was placed on oxycodone on 9/26/2016. 2. This deficiency has the potential to affect all residents. 3. Director of Nursing re-educated Licensed Nurses on 9/21/16 on ensuring that a medication was appropriately labeled to reflect the current physician orders and on process for notifying pharmacy of a change and assuring a label is applied per policy and procedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	09/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

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F 431	Continued From page 37 change in order to change the labeling to reflect the current physician order. Review of R74's current electronic "Clinical Physician Orders", last reviewed on 8/22/16, indicated R74 was started on oxycodone hcl [hydrochloride] tablet 5mg twice a day on 9/12/16. During an interview on 9/16/16 at 8:18am, the Director of Nursing (DON) indicated that nurses are responsible for notifying the pharmacy of any resident medication order changes. The DON confirmed that the pharmacy should have been notified of R74's oxycodone 5mg order change in order for the pharmacy to send the new label and/or medication. Review of the facility's "Acquisition, Receiving, Dispensing, and Storage of Medications" policy, revised 12/15, indicated "...2. Licensed nursing staff members are responsible for ordering (except Schedule II medications) and checking all new orders of medications from the physician's orders. a. The pharmacy needs to be kept up to date on any order changes. b. The medication orders/changes are communicated to the pharmacy. c. The order will include the date of the change, the location name, resident's name, medication name, dosage, route, quantity or duration and strength, diagnosis or indication for use and the physician's name...9. All medications (including medication samples or other medications dispensed by the physician) are packaged in accordance with the location dispensing system and state pharmacy rules. These medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as the expiration date, will be included. New labels will be applied	F 431	4. Director of Nursing or designee will audit changes in medication orders that would require a new label and check to ensure that the label matches the current physician order twice per week times two weeks then once per week times two weeks. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	

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F 431	Continued From page 38 by the pharmacist or the pharmacist's agent as needed. (See Use of Herbal or Natural Remedies.)..."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		10/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 39 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility: (a) failed to ensure staff followed proper infection control practices during the provision of wound care for one (R50) of two residents reviewed for pressure ulcers and (b) failed to maintain sanitary storage of personal resident respiratory equipment for three (R82, R42, and R27) in the Stage 2 Sample of 35. Findings include: 1.Review of R50's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 6/11/16 indicated R50 had a diagnosis that included, but was not limited to, L89.154 (ICD-10 [International Statistical Classification of Diseases and Related Health Problems] code for pressure ulcer of sacral region, stage 4.) Additionally, "Section M-Skin Conditions" revealed R50 had a stage 4 pressure ulcer that was present upon admission that measured 0.8cm (centimeters) in length by 0.7cm in width by 1.5 cm in depth. Review of R50's current electronic "Clinical Physician Orders", last reviewed on 8/4/16, indicated "Foam Dressing Bordered Pad apply to sacrum topically every shift related to pressure ulcer of sacral region, stage 4. Apply collagen particles and ease into area from approx. [approximately] 9 o'clock down to six o'clock. Place calcium alginate silver in remaining open area. Cover with foam bordered dressing. Dc	F 441	F441- Infection Control, Prevent Spread, Linens 1. Inspirometer mouthpiece for R82 is now stored in a bag for protection to prevent contamination. The nasal cannula and inspirometer mouthpiece for R42 is now stored in separate bags for protection to prevent contamination. The nasal cannula for R27 is now stored in bag for protection to prevent contamination. The nebulizer mask for R27 will be stored as per our policy and procedure.R50 is now receiving wound care with proper hand hygiene per facility procedure. 2. This deficiency has the potential to affect all residents who receive wound care. This deficiency has the potential to affect all residents who use respiratory equipment. 3. Director of Nursing re-educated Licensed Nurses on 9/21/2016 ensuring staff follow proper infection control practices during the provision of wound care and maintain sanitary storage of personal resident respiratory equipment. 4. Director of Nursing or designee will audit that inspirometer mouthpieces and nasal cannulas are stored in a bag for	

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F 441	Continued From page 40 [discontinue] when healed and apply to sacrum topically as needed for loose, leaking, or soiled (sic) related to pressure ulcer of sacral region, stage iv." On 9/15/16 at 1:26pm, RN4 was observed providing wound care for R50. The previous dressings had been removed. RN4 cleansed R50's sacral area pressure ulcer wound with gauze pads and an in-house wound cleanser solution. RN4 removed her gloves and donned a new pair of gloves. RN4 failed to perform hand hygiene between the glove changes. RN4 then proceeded to apply collagen particles, silver alginate and a foam border dressing according to physician's orders. During an interview on 9/15/16 at 1:55pm, RN4 confirmed that she did not perform any hand hygiene after removing gloves and before donning a new pair of gloves during R50's provision of wound care. During an interview on 9/16/16 at 8:26am, the Director of Nursing (DON) was informed of the observation that RN4 failed to perform any hand hygiene after glove removal during R50's provision of wound care. The DON confirmed that RN4 was expected to perform hand hygiene after removing her gloves. Review of facility policy "Wound Dressing Change", revised 5/16, page 2 of 3, indicated "...7. Remove soiled dressing and discard in plastic bag, avoiding contact and thus contamination of other surfaces. Remove gloves and discard in same plastic bag. Perform hand hygiene..."	F 441	protection to prevent contamination and nebulizer masks are stored as per policy and procedure three times per week times two weeks, then once per week times 2 weeks. Director of Nursing or designee will audit hand hygiene with dressing changes three times per week times two weeks, then once per week times two weeks. All audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	

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F 441	Continued From page 41 2. On 9/12/16 at 4:42pm, observation during the initial tour revealed the following: R82 - An inspirometer (an instrument for measuring the force, frequency, or volume of inspirations) with the mouth piece laying on the bedside table without a barrier or bagged for protection to prevent contamination. R42 - A nasal cannula (a device used to deliver oxygen through the nose) and an inspirometer laying on the bed side table without a barrier or bagged for protection to prevent contamination. R27 - A nebulizer mask (a machine used for dispensing medication into a fine spray for inhalation) without a barrier or bagged to prevent contamination, and a nasal cannula laying on the overstuffed chair. During an interview on 9/16/16 at 8:00am, the Director of Nursing (DON) stated when the respiratory equipment in the resident's room was not it use, it should have been stored in a bag. The facility did not provide a policy related to storage of respiratory equipment.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 456	F456- We will correct the deficiency as it	10/24/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 456	Continued From page 42 review the facility failed to ensure that 2 out of 2 facility laundry clothing dryers were maintained in a safe operating condition. This deficiency had the potential to affect all 45 residents residing in the facility. Findings include: On 9/15/16 at 7:50am a tour was conducted in the facility laundry room. Also present was the facility Administrator. The bottom of a dryer (lint compartment), located on the left side of the room, was opened. There was a thick amount of lint that was attached to the top and bottom of this area of the machine. An attempt was made to open the second dryer located on the right side of the room. The Administrator said she would call in the maintenance director since he was located on another property. At 8:10am the maintenance director arrived in the laundry room. The maintenance director opened up the first dryer and then opened up the second dryer. He stated that the lint compartments should be cleaned out at the end of each shift, indicating that both had not been cleaned often enough. A review was conducted of the facility procedures entitled, "Laundry Room." This procedure read, "An important aspect of a laundry service program is the maintenance and use of the laundry room(s)...Clean out the dryer lint screens on a frequent and scheduled basis."	F 456	relates to the individual (s) or others by: 1. All residents were impacted by this deficiency. Lint was removed by Maintenance Supervisor and Laundry Department Staff on 9/16/2016. 2. This deficiency has the potential to affect all residents. 3. Maintenance Supervisor re-educated laundry staff on removing lint from the dryers at the end of each shift on 9/16/2016. 4. Maintenance Supervisor or designee will audit that the lint has been removed from the dryers three times a week for two weeks, then once per week for four weeks, then review at QAPI. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by: 10/24/2016	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245476 Y1	A. Building B. Wing Y2	11/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0248	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.15(f)(1)	Completed
LSC	10/24/2016	LSC	10/24/2016	LSC	10/24/2016
ID Prefix F0279	Correction	ID Prefix F0312	Correction	ID Prefix F0314	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed
LSC	10/24/2016	LSC	10/24/2016	LSC	10/24/2016
ID Prefix F0323	Correction	ID Prefix F0371	Correction	ID Prefix F0431	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	10/24/2016	LSC	10/24/2016	LSC	10/24/2016
ID Prefix F0441	Correction	ID Prefix F0456	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. # 483.70(c)(2)	Completed	Reg. #	Completed
LSC	10/24/2016	LSC	10/24/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	12/05/2016	34985	11/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/16/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CXMF

Facility ID: 00058

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245476**

2.STATE VENDOR OR MEDICAID NO.
(L2) **017040200**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/11/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Guillingsrud, HFE NEII 09/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 25, 2016

Ms. Karen Prososki, Administrator
Good Samaritan Society - Pine River
518 Jefferson Avenue, PO Box 29
Pine River, Minnesota 56474

RE: Project Number S5476027

Dear Ms.. Prososki:

On August 11, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 20, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 20, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 11, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 11, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide individualized activities in order to meet the individual interests for 2 of 3 residents (R17, R47) observed to have not been provided activities. Findings include: R17's significant change Minimum Data Set	F 248	Preparation and execution of this response and plan of correction does not constitute an admission or agreement or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance	9/13/16

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

Electronically Signed | 09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 1 (MDS) dated 5/29/16, indicated R17 was diagnosed with Alzheimer's dementia, arthritis and a fractured hip. The MDS also indicated R17 had severe cognitive impairment, required extensive assistance with transfer and was non ambulatory. R17's Activity Interest Data Collection Tool form dated 5/25/16, indicated R17 enjoyed books, magazines, reminiscing, walking, visiting with others, and spiritual activities. The form also indicated R17 was oriented to self and did not like to participate with group activities. The form indicated R17 to was to receive one to one visits with the activity staff. R17's significant change review dated 6/1/16, completed by the activity staff indicated R17 was not able to participate in her regular routine of visiting with staff, reading magazines or sorting through her belongings since she had sustained a fractured hip. The review directed the staff to perform one to one visits with R17. R17's care plan dated 11/26/12, indicated R17 did not like to join in group activities and preferred activities such as resting, reading independently, writing, visits on the phone and rummaging in her room. The plan directed the staff to provide one to one room visits 3-5 times per week. Although R17 did not like to participate in group activities, the following activities were noted to be scheduled: The Activity Calendar for 8/8/16, at 3:30 p.m.	F 248	with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. We will correct the deficiency as it relates to the individual (s) or others by: 1. Resident R17 and R47 were impacted by this deficiency. The Activity Director re-evaluated R17 and R47 to be able to provide individualized activities to meet their individual activity interests. Activities Interest Data Collection Tool for R17 was completed on 8/31/2016. Preference for Customary Routine and Activities was completed on 8/30/2016 for R17. Care plan for R17 was updated with current preferences. 2. All residents have the potential to be affected by this deficiency. 3. Scheduled times for 1:1 visits have been added to the daily activity calendar 3 times per week. Activity Director will re-educate Activity Department staff on 1:1 visits vs. group activities by 9/13/2016. 4. Activity Director or Designee will complete audits to look at 1:1 visits and group activities that residents have attended two times per week for two weeks then once per week for one month, then every two weeks times one month. Audit results will be reviewed by the QAPI Committee for further recommendations.	

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F 248	Continued From page 2 indicated "games" would be offered. R17 was observed in her room during the activity. The Activity calendar on 8/9/16, indicated at 10:00 a.m. a Bible study would be held, at 1:30 p.m. would be "bake day" and at 3:30 p.m. "Fancy Fingers." R17 was not observed to participate in the group activities nor provided with Bible study or nail care in her room. The Activity Calendar on 8/10/16, indicated at 10:00 a.m. "devotions" and 2:00 p.m. "pie social" activities were scheduled. R17 was not observed to participate in the activities or receive pie or spiritual activity in her room. The Activity Calendar on 8/11/16, indicated at 10:00 a.m. "reflections" was scheduled. R17 was not observed to participate in the activity nor were activities staff observed to provide R17 one to one conversation in her room. On 8/9/16, at 4:13 p.m. nursing assistant (NA)-B stated R17 had been independent in her activities prior to a fall in 5/2016, in which she sustained a fractured hip. She stated R17 would ambulate up and down the hallways, she would visit with others in the hallways, call her family and pick up magazines from the magazine rack to read. She stated since the fractured hip, R17 was dependent upon staff for transfers and mobility. NA-B did stated R17's son visited R17 daily. Review of the Documentation Survey Report v2	F 248	5. Correction will be completed by 9/13/2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 3	F 248		

(activity staff documentation) form revealed the following information:
- May 2016, R17 participated in activities on 11 days.
- June 2016, R17 participated in activities on 10 days.
- July 2016, R17 participated in activities on 3 days.
- August 2016, R17 had participated in one activity.

On 8/11/16, at 8:35 a.m. the activity directed stated R17 visited with her family on a regular basis and ate meals in the dining room. She stated R17 did not participate in group activities. She stated R17 had regular visitors from the community, but the activity staff had not offered one to one activities for R17 as indicated. She verified in the past 30 days R17 had only received two one to one visits, whereas her care plan directed the staff to offer one to one activities 3-5 times a week. She stated the activity department had recently had staff changes and the one to one activities had been missed. She stated the one to one visits would need to be increased.

R47's admission MDS dated 5/24/16, indicated R47 had severe cognitive impairment and diagnoses which included dementia, Parkinson's disease and depression. The MDS also indicated it was very important to R47 to participate in religious services or practices and to go outside when the weather was good and somewhat important to do favorite activities, do things with groups of people, and to listen to music. The MDS further indicated R47 was non-ambulatory and was totally dependent upon two persons for transfer and was totally dependent upon one

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F 248	Continued From page 4 person for locomotion on and off the unit. R47's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 5/31/16, indicated R47 had variable alertness and was lethargic at times. R47 remained oriented to self and appeared to be oriented to family as well. Due to Parkinson's disease, R47 had difficulty with speech and making needs known. Staff often needed to anticipate needs. R47's Activity Interest Data Collection Tool dated 6/1/16, indicated R47 had interests in listening to music, singing, educational classes, reminisce, spiritual activities, and traveling. The data collection tool indicated R47 enjoyed spending time with spouse, family and friends and seemed to enjoy music, bake say, socials, special events, and worship/devotions. The data collection tool also indicated R47 needed assistance with transfers and transportation to and from all activities and staff would continue to encourage R47 to attend daily activities outside of room. R47's care plan dated 6/1/16, indicated R47 was dependent on staff for activities, cognitive stimulation, and social interaction related to memory deficit and physical limitations. The care plan indicated R47's preferred activities were Christian music, spending time with spouse and family and worship/devotions. The care plan directed staff to provide 1:1 bedside/in-room visits and activities if unable to attend out of room events, encourage ongoing family involvement, and offer to turn on TV, music in room when resident chooses not to participate in organized	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 5 activities. The Activity Calendar for 8/8/16, at 3:30 p.m. indicated "games" would be offered. R47 was not observed to participate in the activity. The Activity calendar on 8/9/16, indicated the following activities: 10:00 a.m. Bible study, 1:30 p.m. Bake Day and 3:30 p.m. Fancy Fingers. R47 was not observed to participate in the group activities. On 8/10/2016, at 9:21 a.m. R47 was returned to her room and put back to bed after breakfast by NA-C and NA-D. NA-D asked R47 if she would like to watch television and left the room with the TV on. NA-D stated R47 liked music or old movies so indicated she would try to find a station playing that. NA-D also stated as far as activities, R47 enjoyed church activities and stated they would also have R47 go to other activities such as games or group activities. NA-D further stated R47's activity attendance had been decreased due to the need for positioning off of her buttocks. -At 11:15 a.m. R47 was observed to remain resting in bed. The Activity Calendar indicated a Devotions activity took place at 10:00 a.m. On 8/11/2016, at 9:19 a.m. R47 was observed resting in bed with the light off. -At 10:17 a.m. R47 remained in bed. No music or television was playing. The Activity Calendar indicated a Reflections and Readings activity took place at 10:00 a.m.	F 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 248	Continued From page 6 Review of the Documentation Survey Report v2 from 5/18/16, through 8/11/16, revealed R47 was provided the following activities: --May 2016: 1:1 activities once and group activities on 6 days --June 2016: 1:1 activities on 6 days and group activities on 6 days --July 2016: 1:1 activities twice and group activities on 5 days --August 2016: 1:1 activities zero times and group activities once On 8/11/16, t 12:09 p.m. the activity director (AD) stated she would expect R47 to have received activity services at least 2-3 times per week. AD indicated she would also expect alternative activities be provided if R47 did not attend activities out of her room. The Documentation Survey Report from 5/18/16, to 8/11/16, was reviewed with the AD who confirmed beginning 6/19/16, R47's activity participation was lacking. The AD indicated she had been hired 7/1/16, and upon starting with the facility, had focused on services for active residents. The AD confirmed activity services, including 1:1 activities had been lacking for residents with cognitive issues, including R47. The Activity Program policy dated 1/2015, directed the staff to provide individualized activities of interests to enhance the physical, mental and psychosocial well being of each resident based upon the comprehensive assessment.	F 248		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		9/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - PINE RIVER	518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474

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F 282 SS=D	Continued From page 7 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services according to the written care plan for 1 of 3 residents (R28) who required assistance with oral cares and for 1 of 3 residents (R17) who required assistance with activities. Findings include: R17 was not provided oral cares as directed by the care plan. R28's care plan dated 7/11/14, indicated R28 had natural teeth and had the ability to brush her teeth after supples were set up for her by staff. On 8/10/16, from 6:55 a.m. until 7:05 a.m. nursing assistant (NA)-A was observed to assist R28 with morning cares. At no time was R28 provided oral cares. -At 7:10 a.m. R28 was wheeled from her room to the dining room. -At 8:05 a.m. R28 was wheeled back from the dining room to her room by licensed practical nurse (LPN)-A. R28 was not offered oral cares at	F 282	We will correct the deficiency as it relates to the individual (s) or others by: 1. Resident R17 and R28 were impacted by this deficiency. Oral Hygiene Education was provided to the Nursing Assistant on 8/10/16 by Director of Nursing. Activity Director reviewed the care plans for R17 and R28. Activity Director has re-educated activity department staff on group/ 1:1 activities for R17 and R28. 2. All residents who need assistance or are dependent on staff to perform oral hygiene have a potential to be affected by this deficiency. All residents who need assistance with activities have the potential to be affected by this deficiency. 3. Director of Nursing will re-educate Nursing Assistant□s on 9/7/2016 at Nursing Assistant meeting about following care plan for oral hygiene. Activity Director will re-educate on following the care plan for activities for all Activity Department staff on 9/12/2016. 4. Director of Nursing or designee will conduct observation audits to ensure care	

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	245476	A. BUILDING _____ B. WING _____	08/11/2016

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F 282	Continued From page 8 that time. -At 8:15 a.m. R28 was asked if she had brushed her teeth. R28 stated she could not recall brushing her teeth. On 8/10/16, at 9:35 a.m. NA-A confirmed she had not cued R28 to complete oral cares. On 8/10/16, at 11:43 a.m. registered nurse (RN)-C stated she would expect the staff to provide oral cares as directed by the care plan. R17 was not provided activities as directed by the care plan. R17's care plan dated 11/26/12, indicated R17 did not like to join in group activities and preferred activities such as resting, reading independently, writing, visits on the phone and rummaging in her room. The plan directed the staff to provide one to one room visits 3-5 times per week. Although R17 did not like to participate in group activities, the following activities were noted to be scheduled: The Activity Calendar for 8/8/16, at 3:30 p.m. indicated "games" would be offered. R17 was observed in her room during the activity. The Activity calendar on 8/9/16, indicated at 10:00 a.m. a Bible study would be held, at 1:30 p.m. would be "bake day" and at 3:30 p.m. "Fancy Fingers." R17 was not observed to participate in	F 282	plan is being followed for oral hygiene. Observation audits will be completed three times a week on am shift and three times a week on pm shift times 4 weeks, then one time per week on am and pm shifts for four weeks, then review at QAPI. Activity Director or designee will conduct observation audits to ensure care plan is being followed for activities. These audits will be completed one time per week for four weeks, then every other week times four weeks, then review. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by 9/13/2016.	

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F 282	Continued From page 9 the group activities nor provided with Bible study or nail care in her room. The Activity Calendar on 8/10/16, indicated at 10:00 a.m. "devotions" and 2:00 p.m. "pie social" activities were scheduled. R17 was not observed to participate in the activities or receive pie or spiritual activity in her room. The Activity Calendar on 8/11/16, indicated at 10:00 a.m. "reflections" was scheduled. R17 was not observed to participate in the activity nor were activities staff observed to provide R17 one to one conversation in her room. Review of the Documentation Survey Report v2 (activity staff documentation) revealed the following information: -May 2016, R17 participated in activities on 11 days. -June 2016, R17 participated in activities on 10 days. -July 2016, R17 participated in activities on 3 days. -August 2016, R17 had participated in one activity. On 8/11/16, at 8:35 a.m. the activity director confirmed R17 had not received 3-5 one to one activities as directed by her care plan. The Care Plan policy dated 9/2012, directed the staff to provide the necessary care and services to attain or maintain the highest practicable well-being of each resident in accordance with their compressive assessments.	F 282		

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a bladder reassessment upon identification of urinary incontinency decline for 1 of 4 residents (R17) reviewed who had a decline in urinary incontinence. Findings include: R17's Annual Minimum Data Set (MDS) dated 3/21/16, indicated R17 was diagnosed with Alzheimer's dementia, arthritis and osteoarthrosis. It indicated R17 had severe cognitive impairment, was independent in ambulation, toileting and was continent of bowel and bladder. R17's nurse Progress Notes dated 5/9/16, indicated R17 sustained a fall which resulted in a fractured hip.	F 315	We will correct the deficiency as it relates to the individual (s) or others by: 1. Resident R17 was impacted by this deficiency. Review of 3 day intake/ output and Bowel and Bladder was completed by RN on 8/29/2016 for R17. R17□s care plan was reviewed on 8/29/2016. 2. All residents who have a decline in urinary incontinence have a potential to be affected by this deficiency. 3. RN/ Nurse Managers were re-educated on completing bladder reassessments when a significant change is identified on 8/11/2016. Director of Nursing or designee will re-educate licensed nurses about completing bladder reassessments when there is a significant change with the resident. This education will be completed with each individual licensed nurse by 9/13/2016.	9/13/16

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F 315	Continued From page 11 R17's significant change MDS dated 5/29/16, indicated R17 required extensive assistance with transfers, she was non ambulatory, required extensive assistance to toilet and was frequently incontinent of bladder and always incontinent of bowels. R17's Urinary incontinence Care Area Assessment (CAA) dated 6/1/16, indicated R17 was receiving narcotic pain medication related to the hip fracture which caused R17 to be lethargic and R17 may have a decreased awareness of voiding urges. Staff were directed to encourage R17 to maintain her current level of bladder function of at least a 35% continence rate. R17's care plan dated 11/6/12, indicated R17 was independent with toileting and to assist as needed. A second area of the care plan dated 3/26/13, indicated R17 had occasional bladder incontinence and directed the staff to assist with incontinence episodes as R17 allowed. R17's bladder assessment dated 4/13/11, indicated R17 was content of bowel and bladder. R17's medical record lacked any further bladder assessments. On 8/8/16, at 6:05 p.m. R17's family member stated since R17 had fallen, R17 was utilizing incontinent products yet she had not been incontinent of bladder prior to the fall.	F 315	4. Director of Nursing or designee will conduct random audits on residents who have a change in condition related to urinary continence 3 times a month for one month and two times a month for 2 months and Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by 9/13/2016.	

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F 315	Continued From page 12	F 315		

On 8/10/16, from 5:38 a.m. to 8:00 a.m. R17 was continuously observed resting in bed.
-At 8:00 a.m. nursing assistant (NA)-A and licensed practical nurse (LPN)-A were observed to assist R17 with morning cares. R17 was observed wearing a pull up type incontinent product which was saturated in urine. NA-A stated R17 wore incontinent products at all times. R17 refused to transfer out of bed with NA-A and LPN-A.

On 8/10/16, at 10:50 a.m. registered nurse (RN)-D stated R17 had always been continent of bowels and bladder, however, upon returning from the hospitalization and fractured hip, R17 declined very quickly. She stated R17 had been placed on hospice and the family did not expect her to make it. R17 however, had improved and was alert, talkative, and was able to make decision for herself, but remained more dependent upon staff for cares.

On 8/10/16, at 11:36 a.m. RN-C/ MDS coordinator, stated R17 declined greatly after she sustained the fractured hip. She stated a new bladder assessment should have been completed with the change in R17's bladder status. She did not know why this had not been completed.

On 8/11/16, at 11:12 a.m. the director of nursing stated a bladder assessment should be completed upon admission and with a change in status.

The Bowel and Balder Assessment policy dated 9/2012, read: "When a significant change affecting elimination occurs (i.e., decline or improvement), the resident would be

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F 315	Continued From page 13 re-evaluated."	F 315		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure sanitary conditions were maintained in the kitchen. This had the potential to affect all 46 residents who received meals from the kitchen. Findings include: On 8/8/16 at 1:15 p.m. the initial tour of the kitchen was completed with the dietary director and the following was identified: -The dry storage room contained three large bins on wheels. The bins contained flour, sugar and wheat flour. Large scoops were observed to be sitting in the flour and sugar containers. None of the three large bins were observed to have dates indicating when the bins had been filled.	F 371	We will correct the deficiency as it relates to the individual (s) or others by: 1. On 8/10/2016, the scoops were removed from the large storage bins and cleaned; the bins were dated with fill dates. On 8/10/2016, the can opener blade was cleaned. On 8/10/2016, the hood was cleaned. Hood was professionally cleaned on 8/31/2016. Dietary Supervisor or Designee updated the dietary cleaning schedule on 8/31/2016. 2. This deficiency had the potential to affect all 46 residents who received meals from the kitchen. All residents who receive meals from the kitchen have the potential to be affected. 3. Dietary Supervisor or designee will	9/13/16

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F 371	Continued From page 14 -The can opener mounted on the counter next to the main handwashing sink was observed to have a thick build up of black debris on the can opener blade. -The hood vent above the cooking area was observed to be divided into two sections. The section above the steam kettle and griddle was observed to be clean. However; the section above the holding ovens and convection oven was observed to have a thick layer of grey/black debris in the slots of the hood. On 8/10/16, at 11:07 a.m. the sanitation tour was conducted with the dietary manager and the following was identified. -The can opener blade continued to have thick debris on it. The director stated it was to be wiped off daily and ran through the dishwasher once a week. He verified the can opener blade was in need of cleaning. -The scoops had been removed from the flour and sugar bins, however, they were observed to be sitting on top of the bins, dirty. He verified the scoops were not to be kept in the food bins and the dates to which the bins had been filled should be identified on the bins. He stated the bins were emptied every 1-2 months. -The dietary director stated the hood was to be cleaned once a month by the dietary staff members. He verified the hood was in need of cleaning. The Daily cleaning schedule dated 2/2013,	F 371	re-educate the dietary department on following the cleaning schedule for can openers, hood, and scoops. Re-education will also include proper scoop storage and dating of bins when filled. Stove hood vents will be cleaned per policy. This education will be completed by 9/13/2016. 4. Dietary Supervisor or designee will conduct audits on completion of cleaning schedule and fill dates on bins one time each week times 8 weeks, then review. Staff will document daily on audit chart on am shift and pm shift that there are no scoops in the large bins or on top of the bins times 8 weeks, then review. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by 9/13/2016.	

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F 371	Continued From page 15 directed the dietary aide to wipe off the can opener daily. The Ice/Ice Scoop policy dated 2/2013, directed the staff to ensure scoops were not stored in the bins. It directed the staff to store scoops a clear impervious container near the container which required the scoop. The Sanitation of Non-Food Contact Surfaces dated 2/2014, directed the staff to clean the grease trays daily and to establish a cleaning schedule with the maintenance department.	F 371		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain doors in a safe, and sanitary condition for 5 of 10 resident rooms (222, 223, 219, 217, 215) and 1 of 1 tub room door on the north end of the Birch unit. In addition, the facility failed to provide housekeeping and maintenance services necessary to maintain sanitary conditions for 3 of 4 residents (R28, R3, R18) whose wheelchair armrests had torn coverings and/or exposed foam/padding which rendered them uncleanable and for 2 of 2 residents (R19, R42) whose bedrail grab bars were observed to be covered with uncleanable piping foam.	F 456	We will correct the deficiency as it relates to the individual (s) or others by: 1. Resident R28, R3, and R18 were impacted by this deficiency. Wheelchair armrests were replaced on 8/11/2016 for affected residents. Residents R 19 and R42 were impacted by this deficiency. The piping foam was removed on 8/10/2016 on impacted residents. Rooms 222, 223, 219, 217, 215 and tub room on north end of Birch unit were impacted by this deficiency. Supplies were ordered and	9/13/16

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F 456	Continued From page 16 Findings include: On 8/11/16, at 8:45 a.m. an environmental tour was conducted on the North Birch Hallway with the maintenance director. The lower half of the exterior hallway doors of rooms 222, 223, 219, 217 and 215 along with the Birch tub room were observed to have rough gouged/marred edges. The gouged areas left exposed wood which had a potential for splinters. On 8/11/16, at 9:00 a.m. the maintenance director verified the doors on the Birch wing were in need of repair. He stated he could easily fix the marred areas by adding the same door edging which was already on multiple doors throughout the facility. He stated he did not know why the Birch hallway did not have door coverings like other areas of the facility, but he would look into the repairs. He stated if the staff member noticed an area of concern, they were to report this to the maintenance department by filling out a maintenance request slip. He stated he had not been made aware any concerns to the Birch hallway doors. A policy for maintenance repairs was requested and none was provided. Wheelchairs/Grab bars:	F 456	Contractors will install door protectors on affected rooms by 9/13/2016. 2. All resident rooms and resident wheelchairs were rechecked on 8/29/2016. All resident and tub room doors were inspected on 8/29/2016. Doors will be repaired as findings indicate. 3. Director of Nursing and Maintenance Supervisor will educate nursing, housekeeping and maintenance departments on unsanitary conditions related to usage of piping foam and associated risks of torn wheelchair armrests by 9/13/2016. All doors that are in need of repair will be fixed by 9/13/2016. The facility will no longer use piping foam. 4. Maintenance Supervisor/ Designee will complete random observation audits on wheelchairs one time per month times 2 months. Maintenance Supervisor/ Designee will complete monthly maintenance checks on all wheelchairs which will include inspecting armrests. Maintenance Supervisor or designee will complete an observation audit once per month for 2 months to ensure doors are maintained in a safe and sanitary condition. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. Correction will be completed by 9/13/2016.	

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F 456	Continued From page 17 On 8/9/16, at 10:14 a.m. R28's wheelchair was observed to have a 2-3 inch tear in the right arm rest in with exposed foam sticking out of the naugahyde covering. The left arm rest was observed to slightly frayed on the outer side of the arm rest. On 8/9/16, at 10:36 a.m. R19's bed was observed equipped with bilateral grab bars. The grab bars were observed covered with a grey foam covering which was held into place with black tape. On 8/9/16, at 11:06 a.m. R3's wheelchair was observed to have grey foam covering the left bar of the wheelchair where a leg rest may be connected. The grey foam was secured in place with black tape. On 8/10/16, at 1:15 p.m. R42's bed was observed equipped with bilateral grab bars which were covered in grey foam pipe covering and secured with black tape. On 8/10/16, at 1:20 p.m. R18's wheelchair was observed to have an approximate two inch tear in the right armrest with the stuffing sticking out of the naugahyde. On 8/10/16, at 1:30 p.m. registered nurse (RN)-A verified the aforementioned observations. RN-A stated the grey foam pipe covering had been added to the wheelchairs and grab bars as an intervention to prevent injury to the residents. She	F 456		

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F 456	Continued From page 18 stated the residents may have bumped the rails and caused bruises and the foam was added to prevent such bruises. She stated she was not aware of any concerns related to the foam but verified the areas were uncleanable. She verified the wheelchair arms rests were in need of repair. She stated staff were to report any concerns related to resident personal equipment and needed repairs to the maintenance department. She stated she was not aware of the wheelchairs which were in need of repair. A policy related to the care and maintenance of resident personal care equipment was requested and none was provided.	F 456		

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	245476	A. BUILDING **01 - 1985 BUILDING AND ADDITIONS** B. WING _____	**08/10/2016**

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GOOD SAMARITAN SOCIETY - PINE RIVER	**518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on April 03,2014. At the time of this survey, Good Samaritan Society Pine River was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING **01 - 1985 BUILDING AND ADDITIONS** B. WING _____	**08/10/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PINE RIVER	**518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474**

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K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

Fax Number 651-215-0525

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

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Good Samaritan Society of Pine River is a 1-story building with two basements. The building was constructed at five different times. In 1961 the nursing home was built and was determined to be of Type II(111) construction without a basement. In 1968 an addition was constructed to the north of the original building, that was determined to be of Type II(111) construction and has a basement. In 1985 an addition was constructed to the southwest of the 1961 building that was determined to be of Type II(111) construction and has a partial basement. In 1993 an addition was constructed to the west of the 1985 addition that was determined to be of Type II(111) construction. In 1996 the last addition was added to the west of the 1993 addition that was determined to be of

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	245476	A. BUILDING **01 - 1985 BUILDING AND ADDITIONS** B. WING _____	**08/10/2016**

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GOOD SAMARITAN SOCIETY - PINE RIVER	**518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474**

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K 000	Continued From page 2 Type II(111) construction. The building is divided into 7 smoke zones by one and two hour fire barriers. The facility is separated by 2-hour fire barriers form an outpatient physical therapy building. The building and additions are fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification and installed in accordance with NFPA "The National Fire Alarm Code" 1999 edition. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms in the 1961 and 1968 sections have battery operated smoke detectors in them and the sleeping rooms in the 1993 and 1996 additions have smoke detectors that are wired to the facilities electrical system that alarm in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 49 beds and had a census of 45 at the time of the survey. Because the buildings and all additions meet the construction types allowed for existing Health Care buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 018		8/19/16

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K 018	Continued From page 3 hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 1 corridor door according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 15 of the 45 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 7:50 am to 12:00 pm on 08/10/2016 observations and staff interview revealed resident room 206, the door does not close and latch properly. This deficient condition was verified by the Director of Maintenance.	K 018	Preparation and execution of this response and plan of correction does not constitute an admission or agreement or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center ls allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. Area of door for room 206 which was causing impediment was planed to allow proper closing of the fire door. 2.This was completed on 8/19/2016.	

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K 018	Continued From page 4	K 018		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain 1 of several smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect 16 of the 45 residents, and an undtermined amount of staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On the facility tour between 7:50 am to 12:00 pm on 08/10/2016 observations and staff interview revealed the cross corridor doors, in the Birchway corridor do not close properly and cannot resist the passage of smoke. This deficient condition was verified by the Director of Maintenance.	K 027	3.Travis Weber Maintenance Supervisor 1.Contractor removed door and made required repairs to the door to meet the standards. 2.This was completed on 8/30/2016. 3.Travis Weber Maintenance Supervisor	8/30/16
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire	K 029		8/30/16

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K 029	Continued From page 5 extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the corridor and adjacent areas making them untenable, which could negatively affect the exiting capabilities for 15 of the 45 of residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:50 am to 12:00 pm on 08/10/2016 observations and staff interview revealed the oxygen storage room near resident room 205 does not have an automatic closer on the door. This deficient condition was verified by the Director of Maintenance.	K 029	1. Contractor installed automatic door closer on oxygen room. 2. This was completed 8/30/2016. 3. Travis Weber Maintenance Supervisor.	
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to	K 051		9/12/16

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K 051	Continued From page 6 provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 19.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect all residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:50 am to 12:00 pm on 08/10/2016 observations and staff interview revealed four smoke detectors in the Birchway corridor were within 36 inches of an HVAC diffuser. This deficient condition was verified by the Director of Maintenance.	K 051	1. 3 of the 4 diffusers were moved to meet the requirements on 9/1/2016 by HVAC Contractor. HVAC Contractor is scheduled to move last diffuser on 9/12/2016. 2. This was partially completed on 9/1/2016. Final diffuser will be moved on 9/12/2016. 3. Travis Weber, Maintenance Supervisor	

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K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system would function properly in the event of a fire and could negatively affect all 45 residents, staff and visitors. Findings include: On the facility tour between 7:50 am to 12:00 pm on 08/10/2016 observations and staff interview revealed ceiling tiles were missing in the laundry room and in a basement storage closet. This deficient condition was verified by the Director of Maintenance.	K 062	1. Missing ceiling tiles were located and replaced on 8/10/2016. 2. This was completed on 8/10/2016. 3. Travis Weber Maintenance Supervisor	8/10/16
K 075 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not	K 075		8/10/16

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K 075	Continued From page 8 attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of 11 of 45 residents and an undetermined amount of staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On the facility tour between 7:50 am to 12:00 pm on 08/10/2016 observations and staff interview revealed soiled linen containers that exceeded 32 gallons were stored in a corridor alcove near resident room 309. This deficient condition was verified by the Director of Maintenance.	K 075	1. Maintenance Supervisor and Director of Nursing educated nursing staff on storage of large trash and linen carts on 8/10/2016. This will be added to general orientation for new employees going forward. 2. Education was completed on 8/10/2016 and will be added to facility's next general orientation beginning on 9/6/2016. 3. Travis Weber Maintenance Supervisor	

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 25, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5476027

Dear Ms.. Prososki:

The above facility was surveyed on August 8, 2016 through August 11, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.**

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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	00058	A. BUILDING: _____ B. WING _____	08/11/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 8th, 9th, 10th, and 11th, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services according to the written care plan for 1 of 3 residents (R28) who required assistance with oral cares and for 1 of 3 residents (R17) who required assistance with activities. Findings include: R17 was not provided oral cares as directed by the care plan. R28's care plan dated 7/11/14, indicated R28 had natural teeth and had the ability to brush her teeth after supples were set up for her by staff. On 8/10/16, from 6:55 a.m. until 7:05 a.m.	2 565	Licensing Orders were corrected.	9/13/16

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2 565	Continued From page 3	2 565		

nursing assistant (NA)-A was observed to assist R28 with morning cares. At no time was R28 provided oral cares.
-At 7:10 a.m. R28 was wheeled from her room to the dining room.
-At 8:05 a.m. R28 was wheeled back from the dining room to her room by licensed practical nurse (LPN)-A. R28 was not offered oral cares at that time.
-At 8:15 a.m. R28 was asked if she had brushed her teeth. R28 stated she could not recall brushing her teeth.

On 8/10/16, at 9:35 a.m. NA-A confirmed she had not cued R28 to complete oral cares.

On 8/10/16, at 11:43 a.m. registered nurse (RN)-C stated she would expect the staff to provide oral cares as directed by the care plan.

R17 was not provided activities as directed by the care plan.

R17's care plan dated 11/26/12, indicated R17 did not like to join in group activities and preferred activities such as resting, reading independently, writing, visits on the phone and rummaging in her room. The plan directed the staff to provide one to one room visits 3-5 times per week.

Although R17 did not like to participate in group activities, the following activities were noted to be scheduled:

The Activity Calendar for 8/8/16, at 3:30 p.m.

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2 565	Continued From page 4 indicated "games" would be offered. R17 was observed in her room during the activity. The Activity calendar on 8/9/16, indicated at 10:00 a.m. a Bible study would be held, at 1:30 p.m. would be "bake day" and at 3:30 p.m. "Fancy Fingers." R17 was not observed to participate in the group activities nor provided with Bible study or nail care in her room. The Activity Calendar on 8/10/16, indicated at 10:00 a.m. "devotions" and 2:00 p.m. "pie social" activities were scheduled. R17 was not observed to participate in the activities or receive pie or spiritual activity in her room. The Activity Calendar on 8/11/16, indicated at 10:00 a.m. "reflections" was scheduled. R17 was not observed to participate in the activity nor were activities staff observed to provide R17 one to one conversation in her room. Review of the Documentation Survey Report v2 (activity staff documentation) revealed the following information: -May 2016, R17 participated in activities on 11 days. -June 2016, R17 participated in activities on 10 days. -July 2016, R17 participated in activities on 3 days. -August 2016, R17 had participated in one activity. On 8/11/16, at 8:35 a.m. the activity director confirmed R17 had not received 3-5 one to one activities as directed by her care plan.	2 565		

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2 565	Continued From page 5 The Care Plan policy dated 9/2012, directed the staff to provide the necessary care and services to attain or maintain the highest practicable well-being of each resident in accordance with their compressive assessments. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies and provide education for staff regarding care plan implementation. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		9/13/16

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2 910	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a bladder reassessment upon identification of urinary incontinency decline for 1 of 4 residents (R17) reviewed who had a decline in urinary incontinence. Findings include: R17's Annual Minimum Data Set (MDS) dated 3/21/16, indicated R17 was diagnosed with Alzheimer's dementia, arthritis and osteoarthrosis. It indicated R17 had severe cognitive impairment, was independent in ambulation, toileting and was continent of bowel and bladder. R17's nurse Progress Notes dated 5/9/16, indicated R17 sustained a fall which resulted in a fractured hip. R17's significant change MDS dated 5/29/16, indicated R17 required extensive assistance with transfers, she was non ambulatory, required extensive assistance to toilet and was frequently incontinent of bladder and always incontinent of bowels. R17's Urinary incontinence Care Area Assessment (CAA) dated 6/1/16, indicated R17	2 910	Licensing orders corrected.	

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2 910	Continued From page 7	2 910		

was receiving narcotic pain medication related to the hip fracture which caused R17 to be lethargic and R17 may have a decreased awareness of voiding urges. Staff were directed to encourage R17 to maintain her current level of bladder function of at least a 35% continence rate.

R17's care plan dated 11/6/12, indicated R17 was independent with toileting and to assist as needed. A second area of the care plan dated 3/26/13, indicated R17 had occasional bladder incontinence and directed the staff to assist with incontinence episodes as R17 allowed.

R17's bladder assessment dated 4/13/11, indicated R17 was content of bowel and bladder. R17's medical record lacked any further bladder assessments.

On 8/8/16, at 6:05 p.m. R17's family member stated since R17 had fallen, R17 was utilizing incontinent products yet she had not been incontinent of bladder prior to the fall.

On 8/10/16, from 5:38 a.m. to 8:00 a.m. R17 was continuously observed resting in bed.
-At 8:00 a.m. nursing assistant (NA)-A and licensed practical nurse (LPN)-A were observed to assist R17 with morning cares. R17 was observed wearing a pull up type incontinent product which was saturated in urine. NA-A stated R17 wore incontinent products at all times. R17 refused to transfer out of bed with NA-A and LPN-A.

On 8/10/16, at 10:50 a.m. registered nurse

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2 910	Continued From page 8 (RN)-D stated R17 had always been continent of bowels and bladder, however, upon returning from the hospitalization and fractured hip, R17 declined very quickly. She stated R17 had been placed on hospice and the family did not expect her to make it. R17 however, had improved and was alert, talkative, and was able to make decision for herself, but remained more dependent upon staff for cares. On 8/10/16, at 11:36 a.m. RN-C/ MDS coordinator, stated R17 declined greatly after she sustained the fractured hip. She stated a new bladder assessment should have been completed with the change in R17's bladder status. She did not know why this had not been completed. On 8/11/16, at 11:12 a.m. the director of nursing stated a bladder assessment should be completed upon admission and with a change in status. The Bowel and Balder Assessment policy dated 9/2012, read: "When a significant change affecting elimination occurs (i.e., decline or improvement), the resident would be re-evaluated." SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could provide training to the nursing staff on completing bladder reassessments when a significant change is identified. The DON could monitor to assure assessments are completed timely. The quality assessment and assurance committee could audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 910		

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2 910	Continued From page 9 (21) Days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure sanitary conditions were maintained in the kitchen. This had the potential to affect all 46 residents who received meals from the kitchen. Findings include: On 8/8/16 at 1:15 p.m. the initial tour of the kitchen was completed with the dietary director and the following was identified: -The dry storage room contained three large bins on wheels. The bins contained flour, sugar and wheat flour. Large scoops were observed to be sitting in the flour and sugar containers. None of the three large bins were observed to have dates indicating when the bins had been filled. -The can opener mounted on the counter next to the main handwashing sink was observed to have a thick build up of black debris on the can opener blade.	21015	Licensing orders corrected.	9/13/16

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21015	Continued From page 10 -The hood vent above the cooking area was observed to be divided into two sections. The section above the steam kettle and griddle was observed to be clean. However; the section above the holding ovens and convection oven was observed to have a thick layer of grey/black debris in the slots of the hood. On 8/10/16, at 11:07 a.m. the sanitation tour was conducted with the dietary manager and the following was identified. -The can opener blade continued to have thick debris on it. The director stated it was to be wiped off daily and ran through the dishwasher once a week. He verified the can opener blade was in need of cleaning. -The scoops had been removed from the flour and sugar bins, however, they were observed to be sitting on top of the bins, dirty. He verified the scoops were not to be kept in the food bins and the dates to which the bins had been filled should be identified on the bins. He stated the bins were emptied every 1-2 months. -The dietary director stated the hood was to be cleaned once a month by the dietary staff members. He verified the hood was in need of cleaning. The Daily cleaning schedule dated 2/2013, directed the dietary aide to wipe off the can opener daily. The Ice/Ice Scoop policy dated 2/2013, directed the staff to ensure scoops were not stored in the	21015		

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21015	Continued From page 11 bins. It directed the staff to store scoops a clear impervious container near the container which required the scoop. The Sanitation of Non-Food Contact Surfaces dated 2/2014, directed the staff to clean the grease trays daily and to establish a cleaning schedule with the maintenance department. SUGGESTED METHOD OF CORRECTION: The director of dietary or designee could review and/or revise policies and procedures for ensuring sanitation of the kitchen. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21015		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and	21435		9/13/16

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21435	Continued From page 12 recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide individualized activities in order to meet the individual interests for 2 of 3 residents (R17, R47) observed to have not been provided activities. Findings include: R17's significant change Minimum Data Set (MDS) dated 5/29/16, indicated R17 was diagnosed with Alzheimer's dementia, arthritis and a fractured hip. The MDS also indicated R17 had severe cognitive impairment, required extensive assistance with transfer and was non ambulatory. R17's Activity Interest Data Collection Tool form dated 5/25/16, indicated R17 enjoyed books, magazines, reminiscing, walking, visiting with others, and spiritual activities. The form also indicated R17 was oriented to self and did not like to participate with group activities. The form indicated R17 to was to receive one to one visits with the activity staff. R17's significant change review dated 6/1/16, completed by the activity staff indicated R17 was not able to participate in her regular routine of visiting with staff, reading magazines or sorting through her belongings since she had sustained a fractured hip. The review directed the staff to	21435	Licensing orders corrected.	

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21435	Continued From page 13 perform one to one visits with R17. R17's care plan dated 11/26/12, indicated R17 did not like to join in group activities and preferred activities such as resting, reading independently, writing, visits on the phone and rummaging in her room. The plan directed the staff to provide one to one room visits 3-5 times per week. Although R17 did not like to participate in group activities, the following activities were noted to be scheduled: The Activity Calendar for 8/8/16, at 3:30 p.m. indicated "games" would be offered. R17 was observed in her room during the activity. The Activity calendar on 8/9/16, indicated at 10:00 a.m. a Bible study would be held, at 1:30 p.m. would be "bake day" and at 3:30 p.m. "Fancy Fingers." R17 was not observed to participate in the group activities nor provided with Bible study or nail care in her room. The Activity Calendar on 8/10/16, indicated at 10:00 a.m. "devotions" and 2:00 p.m. "pie social" activities were scheduled. R17 was not observed to participate in the activities or receive pie or spiritual activity in her room. The Activity Calendar on 8/11/16, indicated at 10:00 a.m. "reflections" was scheduled. R17 was not observed to participate in the activity nor were activities staff observed to provide R17 one to one conversation in her room.	21435		

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21435	Continued From page 14 On 8/9/16, at 4:13 p.m. nursing assistant (NA)-B stated R17 had been independent in her activities prior to a fall in 5/2016, in which she sustained a fractured hip. She stated R17 would ambulate up and down the hallways, she would visit with others in the hallways, call her family and pick up magazines from the magazine rack to read. She stated since the fractured hip, R17 was dependent upon staff for transfers and mobility. NA-B did stated R17's son visited R17 daily. Review of the Documentation Survey Report v2 (activity staff documentation) form revealed the following information: - May 2016, R17 participated in activities on 11 days. - June 2016, R17 participated in activities on 10 days. - July 2016, R17 participated in activities on 3 days. - August 2016, R17 had participated in one activity. On 8/11/16, at 8:35 a.m. the activity directed stated R17 visited with her family on a regular basis and ate meals in the dining room. She stated R17 did not participate in group activities. She stated R17 had regular visitors from the community, but the activity staff had not offered one to one activities for R17 as indicated. She verified in the past 30 days R17 had only received two one to one visits, whereas her care plan directed the staff to offer one to one activities 3-5 times a week. She stated the activity department had recently had staff changes and the one to one activities had been missed. She stated the one to one visits would need to be increased.	21435		

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21435	Continued From page 15 R47's admission MDS dated 5/24/16, indicated R47 had severe cognitive impairment and diagnoses which included dementia, Parkinson's disease and depression. The MDS also indicated it was very important to R47 to participate in religious services or practices and to go outside when the weather was good and somewhat important to do favorite activities, do things with groups of people, and to listen to music. The MDS further indicated R47 was non-ambulatory and was totally dependent upon two persons for transfer and was totally dependent upon one person for locomotion on and off the unit. R47's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 5/31/16, indicated R47 had variable alertness and was lethargic at times. R47 remained oriented to self and appeared to be oriented to family as well. Due to Parkinson's disease, R47 had difficulty with speech and making needs known. Staff often needed to anticipate needs. R47's Activity Interest Data Collection Tool dated 6/1/16, indicated R47 had interests in listening to music, singing, educational classes, reminisce, spiritual activities, and traveling. The data collection tool indicated R47 enjoyed spending time with spouse, family and friends and seemed to enjoy music, bake say, socials, special events, and worship/devotions. The data collection tool also indicated R47 needed assistance with transfers and transportation to and from all activities and staff would continue to encourage R47 to attend daily activities outside of room.	21435		

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21435	Continued From page 16 R47's care plan dated 6/1/16, indicated R47 was dependent on staff for activities, cognitive stimulation, and social interaction related to memory deficit and physical limitations. The care plan indicated R47's preferred activities were Christian music, spending time with spouse and family and worship/devotions. The care plan directed staff to provide 1:1 bedside/in-room visits and activities if unable to attend out of room events, encourage ongoing family involvement, and offer to turn on TV, music in room when resident chooses not to participate in organized activities. The Activity Calendar for 8/8/16, at 3:30 p.m. indicated "games" would be offered. R47 was not observed to participate in the activity. The Activity calendar on 8/9/16, indicated the following activities: 10:00 a.m. Bible study, 1:30 p.m. Bake Day and 3:30 p.m. Fancy Fingers. R47 was not observed to participate in the group activities. On 8/10/2016, at 9:21 a.m. R47 was returned to her room and put back to bed after breakfast by NA-C and NA-D. NA-D asked R47 if she would like to watch television and left the room with the TV on. NA-D stated R47 liked music or old movies so indicated she would try to find a station playing that. NA-D also stated as far as activities, R47 enjoyed church activities and stated they would also have R47 go to other activities such as games or group activities. NA-D further stated R47's activity attendance had been decreased due to the need for positioning off of her buttocks. -At 11:15 a.m. R47 was observed to remain	21435		

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	00058	A. BUILDING: _____ B. WING _____	08/11/2016

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21435	Continued From page 17	21435		

resting in bed. The Activity Calendar indicated a Devotions activity took place at 10:00 a.m.

On 8/11/2016, at 9:19 a.m. R47 was observed resting in bed with the light off.
-At 10:17 a.m. R47 remained in bed. No music or television was playing. The Activity Calendar indicated a Reflections and Readings activity took place at 10:00 a.m.

Review of the Documentation Survey Report v2 from 5/18/16, through 8/11/16, revealed R47 was provided the following activities:

--May 2016: 1:1 activities once and group activities on 6 days
--June 2016: 1:1 activities on 6 days and group activities on 6 days
--July 2016: 1:1 activities twice and group activities on 5 days
--August 2016: 1:1 activities zero times and group activities once

On 8/11/16, t 12:09 p.m. the activity director (AD) stated she would expect R47 to have received activity services at least 2-3 times per week. AD indicated she would also expect alternative activities be provided if R47 did not attend activities out of her room. The Documentation Survey Report from 5/18/16, to 8/11/16, was reviewed with the AD who confirmed beginning 6/19/16, R47's activity participation was lacking. The AD indicated she had been hired 7/1/16, and upon starting with the facility, had focused on services for active residents. The AD confirmed activity services, including 1:1 activities had been lacking for residents with cognitive issues,

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21435	Continued From page 18 including R47. The Activity Program policy dated 1/2015, directed the staff to provide individualized activities of interests to enhance the physical, mental and psychosocial well being of each resident based upon the comprehensive assessment. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and provide staff education related to the provision of activity services. The administrator or designee could develop an auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21435		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain doors in a safe, and sanitary	21695	Licensing orders corrected.	9/13/16

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21695	Continued From page 19 condition for 5 of 10 resident rooms (222, 223, 219, 217, 215) and 1 of 1 tub room door on the north end of the Birch unit. In addition, the facility failed to provide housekeeping and maintenance services necessary to maintain sanitary conditions for 3 of 4 residents (R28, R3, R18) whose wheelchair armrests had torn coverings and/or exposed foam/padding which rendered them uncleanable and for 2 of 2 residents (R19, R42) whose bedrail grab bars were observed to be covered with uncleanable piping foam. Findings include: On 8/11/16, at 8:45 a.m. an environmental tour was conducted on the North Birch Hallway with the maintenance director. The lower half of the exterior hallway doors of rooms 222, 223, 219, 217 and 215 along with the Birch tub room were observed to have rough gouged/marred edges. The gouged areas left exposed wood which had a potential for splinters. On 8/11/16, at 9:00 a.m. the maintenance director verified the doors on the Birch wing were in need of repair. He stated he could easily fix the marred areas by adding the same door edging which was already on multiple doors throughout the facility. He stated he did not know why the Birch hallway did not have door coverings like other areas of the facility, but he would look into the repairs. He stated if the staff member noticed an area of concern, they were to report this to the maintenance department by filling out a maintenance request slip. He stated he had not been made aware any concerns to the Birch	21695		

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21695	Continued From page 20 hallway doors. A policy for maintenance repairs was requested and none was provided. Wheelchairs/Grab bars: On 8/9/16, at 10:14 a.m. R28's wheelchair was observed to have a 2-3 inch tear in the right arm rest in with exposed foam sticking out of the naugahyde covering. The left arm rest was observed to slightly frayed on the outer side of the arm rest. On 8/9/16, at 10:36 a.m. R19's bed was observed equipped with bilateral grab bars. The grab bars were observed covered with a grey foam covering which was held into place with black tape. On 8/9/16, at 11:06 a.m. R3's wheelchair was observed to have grey foam covering the left bar of the wheelchair where a leg rest may be connected. The grey foam was secured in place with black tape. On 8/10/16, at 1:15 p.m. R42's bed was observed equipped with bilateral grab bars which were covered in grey foam pipe covering and secured with black tape. On 8/10/16, at 1:20 p.m. R18's wheelchair was observed to have an approximate two inch tear in	21695		

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21695	Continued From page 21 the right armrest with the stuffing sticking out of the naugahyde. On 8/10/16, at 1:30 p.m. registered nurse (RN)-A verified the aforementioned observations. RN-A stated the grey foam pipe covering had been added to the wheelchairs and grab bars as an intervention to prevent injury to the residents. She stated the residents may have bumped the rails and caused bruises and the foam was added to prevent such bruises. She stated she was not aware of any concerns related to the foam but verified the areas were uncleanable. She verified the wheelchair arms rests were in need of repair. She stated staff were to report any concerns related to resident personal equipment and needed repairs to the maintenance department. She stated she was not aware of the wheelchairs which were in need of repair. A policy related to the care and maintenance of resident personal care equipment was requested and none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance reporting resident equipment repair needs. The DON or designee, could coordinate with maintenance and nursing staff to conduct periodic audits of resident wheelchairs to ensure needed repairs are provided. The director of facility operations or his designee could develop a system for staff to report any concerns with the physical plant. All facility staff could be educated on these systems.	21695		

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21695	Continued From page 22 The director of facility operations or his designee could develop a monitoring system to ensure ongoing compliance. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		