DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 2, 2024

Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

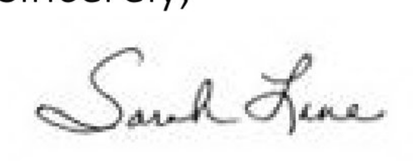
RE: CCN: 245403
Cycle Start Date: November 29, 2023

Dear Administrator:

On January 2, 2024, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2023

Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

RE: CCN: 245403
Cycle Start Date: November 29, 2023

Dear Administrator:

On November 29, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by February 29, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 29, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

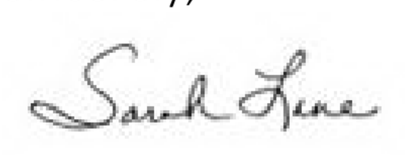
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/27/23 to 11/29/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		12/22/23

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

Electronically Signed | 12/22/2023

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
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement emergency and standby power system routine testing for generator safety checks. This deficient practice had the potential to affect all 45 current residents in the facility. Findings include: On 11/28/23 between 10:00 a.m. and 2:00 p.m., it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing the generator had a four hour load bank test completed within the last 36 months. During an interview on 11/29/23 at 9:30 a.m., the administrator verified this deficient finding at the time of discovery.	E 041	E041 -Hospital CAH and LTC Emergency Power Facility maintenance staff completed the 4-Hour Load Bank Testing for 36 months for the facility in the lookback versus subcontracting this service with an independent contractor. Historically, this has been an acceptable practice for long-term care facilities. All residents have the potential to be affected by this deficient practice. Good Samaritan Society – Battle Lake entered an automatic renewal contract to complete this 4-hour load bank every 36 months if effort to prevent recurrent deficient practices in the years to come. The deficient practice of the 4-hour load bank testing was completed on 12/12/23 by an independent contracted vendor. This will be reviewed annually to ensure ongoing compliance with the 4 hour load bank testing. Education was provided to the Maintenance Director and Administrator as it relates to Emergency Generator Load Bank Testing. Corrective actions will be monitored and completed by the Administrator and Maintenance Director. Corrective action will be reviewed by the Quality Assurance Committee. Date of Corrective Action – 12/22/23	
F 000	INITIAL COMMENTS	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 4 On 11/27/23 to 11/29/23, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		12/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 812	Continued From page 5 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dishwasher temperatures were maintained according to manufacturer's guidelines to assure sanitization of dishware. This deficient practice had the potential to affect all 45 residents who received food from the kitchen. Findings include: During an observation on 11/27/23 at 7:01 p.m., dietary aide (DA)-A washed the supper dishes. DA-A set some plates and glasses on a plastic rack near the entrance of the Hobart dishwasher. After scraping and rinsing the dishes, DA-A placed them into the dishwasher and started the machine. The digital gauge on the front of the dishwasher indicated the wash cycle displayed an E7 error code throughout the wash and rinse cycle with a fix it wrench symbol identified as well. The wash cycle temperature ran between 139 to 140 degrees Fahrenheit (F) and the rinse cycle reached 187 degrees F. DA-A repeated the process with another rack of supper dishes and the wash cycle temperature ranged between 137 to 138 degrees F. DA-A reported the dishwasher had been displaying the error code E7 and the fix it wrench for a couple of weeks and DA-A had not reported it to anyone. The metal plate on the front of the dishwasher included instructions for the wash temperature to reach 150 degrees F and the rinse temperature to reach 180 degrees F.	F 812	F812 – Food Procurement, Store/Prepare/Serve-Sanitary The Maintenance Director completed the de-liming process of the machines and the facility contractor was called to assist in the repair and review of the dishwashing machines on 12/18/23. Dietary staff were educated on the importance of washing all dishes at the appropriate thermal washing temperatures of 150-degrees and 180-degree rinse. Dietary staff were educated on the need to complete a work order and when to place the machine out of service in the event that the dishwasher is not getting to proper temperatures or malfunctioning as well as on other additional actions required. In event of the machine being placed out of service, either disposal dishware will be utilized or dishwashing will occur in a secondary location that has safe washing temperatures. All residents have the potential to be affected by this deficient practice. Dietary Manager or Designee visually audited the sanitation process of the dishwashing units 2x for 1 week. Auditing will continue 2x/week per dishwashing machine for 4 consecutive weeks. Dietary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 812	Continued From page 6 During an observation on 11/28/23 at 10:06 a.m., DA-C loaded the dishwasher with dirty dishes and the temperature during the wash cycle reached 138 degrees F during the wash cycle and 189 degrees F during the rinse cycle. DA-C stated the dishwasher temperature usually ranged between 130 to 160 degrees F. DA-C indicated she worked at the facility for several years and understood the wash temperature needed to be greater than 125 degrees F. During an interview on 11/27/23 at 10:25 a.m. , the dietary manager (DM) indicated the facility utilized hot water sanitation and the temperatures were expected to reach 150 degrees F for the wash cycle and 190 degrees F for the rinse cycle. During a follow up interview on 11/28/23 at 12:07 p.m., DM indicated staff were expected to report any concerns directly to DM and staff would run the same dishes again to ensure proper temperature. During a follow-up interview on 11/28/23 at 2:35 p.m., DM indicated was not aware the wash and rinse cycles had not been reaching the necessary temperature to sanitize the dishes. The facility forms titled Dish Machine Temperature Log Chemical Sanitizing Log found on the Cottonwood unit and the form titled Dish Machine Temperature Log Thermal Sanitizing for the Fisherman's unit included columns to record the wash cycle, final rinse cycle, and (staff) initials for Breakfast Meal, Noon Meal and Evening Meal. Review of the logs from 10/1/23 through 11/28/23, identified the following;	F 812	Manager or Designee will perform oversight in dishwashing logs 3x/week for 4 weeks and 1x/month for two months thereafter in review of completeness, actions taken and compliance with proper/safe dishwashing temperatures. All audits will be reviewed and monitored by the Quality Assurance Committee and evaluated for the need of potential changes in audit frequencies and/or procedural changes to ensure continued compliance with safe dishwashing temperatures. Date of Corrective Action – 12/28/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 812	Continued From page 7 Fisherman's Unit October 2023: -10/1/23, no morning, noon, evening cycles recorded. -10/7/23, evening wash cycle was recorded at 149 degrees. -10/8/23, no morning rinse cycle recorded , no noon cycle recorded. -10/12/23, evening wash cycle was recorded at 147 degrees. -10/13/23, no morning cycle recorded. -10/19/23, no evening cycle recorded. -10/26/23, evening wash cycle was recorded at 142 degrees F. -10/28/23, evening entry scribbled out. -10/29/23, evening wash cycle was recorded at 140 degrees F. -10/31/23, no evening cycle recorded. Review of the form revealed four of the documented entries identified the wash cycle temperature had not reached the required 150 degrees to achieve proper sanitization. Cottonwood Unit October 2023 -10/7/23, no evening wash cycle recorded. -10/18/23, no evening wash cycle recorded. -10/21/23, evening wash cycle was recorded at 147 degrees. -10/22/23, morning wash cycle was recorded at 134 degrees, evening wash cycle was recorded at 147 degrees. -10/25/23, evening wash cycle was recorded at 109 degrees. -10/26/23, no noon cycle recorded. -10/27/23, evening wash cycle was recorded at	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 812	Continued From page 8 115 degrees. -10/28/23, evening wash cycle was recorded at 148 degrees. -10/30/23, evening wash cycle was recorded at 130 degrees. -10/31/23, evening rinse cycle was recorded at 179 degrees. Review of the form revealed seven of the documented entries identified the wash cycle temperature had not reached the required 150 degrees to achieve proper sanitation. In addition, three of the documented entries identified the rinse cycle temperatures had not reached the required 180 degrees to achieve the proper sanitation. Fisherman's Unit November 2023: -11/2/23, no evening cycle recorded. -11/4/23, morning rinse cycle was recorded at 175 degrees, evening wash cycle was recorded at 140 degrees. -11/5/23, morning rinse cycle was recorded at 170 degrees, noon rinse cycle was recorded at 179 degrees. -11/9/23, evening wash cycle was recorded at 147 degrees. -11/10/23, evening wash cycle was recorded at 143 degrees. -11/12/23, evening wash cycle was recorded at 145 degrees. -11/13/23, evening wash cycle was recorded at 142 degrees. -11/14/23, evening rinse cycle was recorded at 160 degrees. -11/16/23, evening wash cycle was recorded at 147 degrees.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 812	Continued From page 9 -11/17/23, evening wash cycle was recorded at 146 degrees. -11/23/23, evening wash cycle was recorded at 148 degrees. -11/25/23, evening rinse cycle was recorded at 179 degrees. -11/26/23, no noon cycle recorded, evening wash cycle was recorded at 149 degrees. -11/27/23, wash cycle was recorded at 140 degrees. Review of the form revealed ten of the documented entries identified the wash cycle temperature had not reached the required 150 degrees to achieve proper sanitation. In addition, five of the documented entries identified the rinse cycle temperatures had not reached the required 180 degrees to achieve the proper sanitation. Cottonwood Unit November 2023: -11/3/23, no evening cycle recorded. -11/4/23, evening wash cycle was recorded at 144 degrees. -11/5/23, evening wash cycle was recorded at 126 degrees. -11/12/23, evening wash cycle was recorded at 145 degrees. -11/13/23, morning wash cycle was recorded at 122 degree, no noon cycle recorded. -11/15/23, no noon cycle recorded. -11/17/23, evening wash cycle was recorded at 138 degrees. -11/20/23, evening wash cycle was recorded at 133 degrees. -11/21/23, no evening cycle recorded. -11/25/23, evening wash cycle was recorded at 149 degrees.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 812	Continued From page 10 -11/27/23, evening wash cycle was recorded at 144 degrees. -11/28/23, morning wash cycle was recorded at 142 degrees. Review of the form revealed nine of the documented entries identified the wash cycle temperature had not reached the required 150 degrees to achieve proper sanitation. During a telephone interview on 11/28/23 at 2:47 p.m., the Hobart representative from the dishwasher manufacturer, verified the facility used hot water sanitation dishwashers. The representative explained wash cycle temperatures were expected to reach 150 degrees minimum 150 and rinse cycle temperatures were expected to reach a minimum 180 degrees. The representative indicated temperatures had to reach the minimum for both cycles to sterilize by getting the plate temperature to 160 degrees. The infection control log was reviewed from 10/1/23. to 11/28/23, and no food borne illnesses had been identified. The LXi Series Dishwasher owner's manual provided by the facility specified for hot water sanitizing the wash temperature required was 150 degrees F, and the final rinse temperature was 180 degrees F. The facility policy titled Warewashing-Mechanical and Manual-Food and Nutrition dated 4/02/2023, identified for High-temperature machine the temperatures must be maintained at a minimum of 150 degrees F for the wash cycle and the rinse cycle temperature must be maintained at a	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 812	Continued From page 11 minimum of 180 degrees F per gauge. The policy indicated the dish machine temperature log must be completed by dining service employees directly involved in the dishwashing process prior to running any item through the dish machine. This ensured the wash and rinse temperatures were properly monitored and controlled. Instructions included to cease dishwashing when temperatures were below required levels and to report temperatures that were below the required levels to the director of dining immediately. The policy instructed staff to sanitize items in the pot-and-sink with approved sanitizer at manufacturer-recommended strength if the heaters were not operating properly.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		12/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 880	Continued From page 12 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 880	Continued From page 13 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal laundry was transported in a manner that prevented risk of contamination for 3 of 6 hallways observed for linen transportation. Findings include: Review of Centers for Disease Control (CDC) guidance, Appendix D - Linen and Laundry Management updated 5/4/23, identified linens must be sorted, packaged, transported, and stored in a manner that prevented risk of contamination by dust, debris, soiled linens or soiled items. During an observation on 11/27/23 at 12:16 p.m., in the cottonwood hallway laundry aide (LA)-A exited R21's room and hung up hangers on an uncovered laundry cart in the hallway. LA-A proceeded to remove laundry from the uncovered cart and placed the laundry in R10's closet. LA-A pushed the uncovered laundry cart down the hallway past two residents and one staff member who were in the hallway. LA-A removed laundry from the uncovered cart and placed the laundry in R24's closet. Administrator walked by the uncovered laundry cart and closed the cover on the laundry cart. During an observation on 11/28/23 at 11:55 a.m., in the fisherman's hallway, LA-A stood at an	F 880	F880 – Infection Prevention and Control The laundering and drying clothes and linens policy was reviewed with the Infection Control Preventionist, Director of Nursing, Administrator, and Director of Environmental Services. Application of this policy was reviewed in conjunction with the current facility practices. Nursing, housekeeping, and laundry staff have been educated on the safe handling, storage, processing, and transportation of linens in effort to prevent the spread of infection. All residents have the potential to be affected by this deficient practice. Infection Control Preventionist or Designee will be responsible for the audits of the handling, storage, processing, and transporting of linens. Audits will be completed 4x/week for 4 weeks and monthly for 2 months thereafter regarding the handling of linen and linen delivery to ensure ongoing compliance with infection control and prevention techniques. All audits will be reviewed and results monitored by the Quality Assurance Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 880	Continued From page 14 uncovered laundry cart and removed laundry from the cart and placed the laundry in R27's closet. LA-A proceeded to place two empty hangers from R27's closet on the uncovered laundry cart. LA-A then covered the laundry cart and wheeled the cart down the hall. LA-A stopped in the Heritage hallway, uncovered the cart, removed laundry from the cart and left the cart uncovered while she placed the laundry in R5's closet. During an interview on 11/28/23 at 12:03 p.m., LA-A confirmed the personal laundry she had not been covered. LA-A stated her usual practice was to ensure the laundry cart was covered however indicated she would leave the cart uncovered at times while she delivered the personal laundry. During an interview on 11/28/23 at 3:40 p.m., environmental services supervisor (ESS) stated she was unaware laundry was being delivered in an uncovered cart. ESS stated her expectation was laundry would always be covered while being delivered. During an interview on 11/28/23 at 3:48 p.m., director of nursing (DON) stated stated staff were expected to deliver laundry in a covered cart. During an interview on 11/29/23 at 7:33 a.m., administrator verified the laundry cart had been uncovered on 11/27/23. Administrator stated she had covered the laundry cart when she noticed it was not covered. Administrator indicated her expectation was laundry would have been covered while being delivered. Review of a facility policy titled Laundering and Drying Clothes and Linens revised 2/16/23,	F 880	Date of Corrective Action – 12/28/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 880	Continued From page 15 indicated laundry should be packaged, transported and stored in a manner that ensured cleanliness and protected the laundry from dust and soil.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883		12/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 883	Continued From page 16 immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R14, R33, R 34 and R40) were offered or received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the Current CDC recommendations 3/15/2023, revealed the CDC identified adults 65 and older who had previously received both PCV13 and PPSV23 at age 65 and older, based on shared clinical decision-making, should receive one dose of PCV20 at least five years after the last pneumococcal vaccine dose.	F 883	F883 - Influenza and Pneumococcal Immunizations The Infection Preventionist or Designee validated that R14 and R33 were educated, offered and administered and/or have a documented refusal of the pneumococcal conjugate vaccine (PVC 20) as recommended by the Centers for Disease Control (CDC). R34 and R40 expired prior to the administration vaccine and the date certain. All residents have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 883	Continued From page 17 Review of R 14's facesheet identified R14, age 100 was admitted to the facility on 4/3/23. Review of R14's Minnesota Immunization Information Connection (MIIC) undated, identified R14 had received PPSV23 on 11/21/2011, and the the PCV13 on 4/21/2015. R14's medical record lacked documentation R14 had been offered or received the PCV20 vaccine. Review of R33's facesheet identified R33, age 89 was admitted to the facility on 4/10/23. Review of R33's MIIC undated identified R33 had received PPSV23 on 1/6/2000 and 8/27/2007 and received the PCV13 on 11/23/2016. R33's medical record lacked documentation R33 had been offered or received the PCV20 vaccine. Review of R34's facesheet identified R34, age 80 was admitted to the facility on 10/26/22. Review of R34's MIIC undated identified R34 had received PPSV23 on 1/12/2001, and the PCV13 on 5/4/2015. R34's medical record lacked documentation R34 had been offered or received the PCV20 vaccine. Review of R40's face sheet identified R40, age 83 was admitted to the facility on 6/28/23. Review of R40's MIIC undated identified R40 had received PCV13 on 4/17/2017, and PPSV23 on 5/16/2018. R40's medical record lacked documentation R40 had been offered or received the PCV20 vaccine. During an interview on 11/28/23 at 2:52 p.m., infection preventionist (IP) confirmed R14, R33, R34, and R40 had not been offered or received the pneumococcal vaccinations as recommended by the CDC. IP stated the expectation was the facility would offer and administer all vaccinations	F 883	All residents of the facility were reviewed and offered the PVC 20 vaccination if eligibility requirements were met to ensure correction of this deficient practice. All new admissions will be reviewed by the Infection Control Preventionist or Designee to determine eligibility requirements. All eligible residents will be provided education, offered and administered the PVC 20 vaccinations, or document refusals as deemed appropriate. Education was provided by the Director of Nursing to the Infection Preventionist and Case Managers as it relates to immunizations. Audits for compliance with pneumococcal immunizations will occur on 5 residents including all new admissions per week for 4 weeks, and 1x/ month for two months thereafter to ensure ongoing compliance. All audits will be reviewed and results monitored by the Quality Assurance Committee. Date of Corrective Action - 12/28/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 883	Continued From page 18 per CDC recommendations. During an interview on 11/29/23 at 11:45 a.m., director of nursing (DON) stated she was aware of the CDC recommendations for the pneumococcal vaccinations. DON confirmed R 14, R33, R34, and R40 had not received the pneumococcal vaccinations as recommended by the CDC. DON stated her expectation would have been that all residents would have been offered and received all pneumococcal vaccines per Centers For Disease Control (CDC) recommendations. Review of a facility policy titled Immunizations/Vaccinations for residents, Pneumococcal, Influenza, Covid-19, Other, AL,R/S,LTC, HBS-Enterprise revised 9/21/23, indicated it is recommended that all clients and residents receive pneumococcal vaccinations per CDC guidelines for eligibility and timing.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 11/28/2023 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Battle Lake was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 12/22/2023

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
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

(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
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Good Samaritan Society Battle Lake is a 1-story building, without a basement. The original building was built in 1973 and was determined to be Type II(000) construction. In 1994 additions to the north of the north wing (Occupational and Physical Therapy - OT/PT) was constructed. The 1994 addition was determined to be Type V(111) construction and is separated by a 2 hour fire	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

(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
K 000	Continued From page 2 barrier. The south east addition was determined to be Type II (000) construction. In 2004 a small vestibule was added to the west wing which included a walk in freezer, which is Type II (000) construction. In 2007 a connecting link, to the new assisted living apartments, was added to the south wing and was determined to be Type V (111) and is separated by a 2 hour fire barrier. . In 2010 an entrance addition was constructed to the north of the dining room which is 1-story, no basement and Type II (000) construction. In 2011 a 16 bed addition was added to the east of the north wing and was determined to be Type II (111) and a 8 bed addition was added to the east of the south east wing and was determined to be Type II (111) construction. The building is divided into 3 smoke compartments by 30 minute rated fire barriers. Building was surveyed as one facility. The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems . A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarm Code" that is monitored for automatic fire department notification. The facility has a capacity of 55 beds with a census of 45 residents at the time of the inspection. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101	K 324		12/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

(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
K 324	Continued From page 3 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9) and 19.3.2.5.4. This deficient finding could have an patterned impact on the residents within the facility. Findings include: On 11/28/2023 between 10:00 AM and 2:00 PM, it	K 324	K324 □ Cooking Facilities Facility maintenance staff installed oven electrical plug lockout/tagout devices with keyed padlocks. These devices were installed on all three ovens to prevent ongoing use of the cooking device. With the installation of the lockout/tagout plug device, the stoves are inoperable. All residents are protected by the plug	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

(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
K 324	Continued From page 4 was revealed by observation that the lockout switches installed on the three residential stoves located in the PT Room, and in each neighborhood kitchen were not on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 324	lockout/tagout devices resulting in the machines being inoperable. Education was provided to the Maintenance Director and Administrator on the requirements of the 120-minute automatic shutoff timers required for safe use of the ovens. Keys for the lockout/tagout devices will be maintained only with the Director of Maintenance and Administrator. Devices will remain inoperable unless compliance of 120-minute shutoff timers are met. Corrective actions will be monitored and completed by the Administrator and Maintenance Director. Corrective action will be reviewed by the Quality Assurance Committee. Date of Corrective Action 12/28/23	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months	K 918		12/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515**

(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
K 918	Continued From page 5 for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/28/2023 between 10:00 AM and 2:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the generator had a four (4) hour load bank	K 918	K918 - Electrical Systems - Essential Electric System Maintenance and Testing Facility maintenance staff completed the 4-Hour Load Bank Testing for 36 months for the facility in the lookback versus subcontracting this service with an independent contractor. Historically, this has been an acceptable practice for long-term care facilities. All residents have the potential to be affected by this deficient practice. Good Samaritan Society - Battle Lake entered an automatic renewal contract to complete this 4-hour load bank every 36 months if effort to prevent recurrent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

(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
K 918	Continued From page 6 test completed within the last 36 months. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 918	deficient practices in the years to come. The deficient practice of the 4-hour load bank testing was completed on 12/12/23 by an independent contracted vendor. This will be reviewed annually to ensure ongoing compliance with the 4 hour load bank testing. Education was provided to the Maintenance Director and Administrator as it relates to Emergency Generator Load Bank Testing. Corrective actions will be monitored and completed by the Administrator and Maintenance Director. Corrective action will be reviewed by the Quality Assurance Committee. Date of Corrective Action - 12/13/23	